LIBERIA NATIONAL MULTISECTORAL HIV and AIDS MONITORING AND EVALUATION PLAN

NATIONAL AIDS COMMISSION

REPUBLIC OF LIBERIA

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i. FOREWORD

Liberia reported the first case of HIV in 1985 HIV and AIDS. Since then the numbers of Liberians living with or affected by HIV continues to increase from and by 2010 38,000 were estimated to ne living and affected by HIV and AIDS and the number of AIDS orphans is also increasing. Therefore HIV prevention, treatment, care, support and impact mitigation are undertaken through concerted efforts of stakeholders from all sectors. These efforts have resulted in increases in resources and the Government, international donors and civil society organizations supported programs.

Stakeholders in Liberia have developed and are implementing the National HIV and AIDS Strategic Framework II 2010-2014. Therefore the main purpose of this M&E plan is to assess the extent to which the goals contained in the NSF are achieved. The M&E plan avails critical data and strategic information used for expanding and scaling up provision of high quality HIV and AIDS services in the country. The required information is generated in a systematic and organized manner through the implementation of this National Multi-sectoral HIV and AIDS M&E Plan. This M&E Plan is developed within the framework of the *three ones principles* which stipulates that every country should have: "One Agreed upon AIDS Action Framework" that provides the basis for coordinating the work of all partners, "One National AIDS Coordinating Authority" with a broad-based multisectoral mandate, and "One Agreed Country M&E system".

The overall goal of the national, multi-sectoral HIV and AIDS M&E system is to generate and disseminate high quality, relevant, timely, and strategic information that will guide stakeholders to measure and improve the HIV response in Liberia.' The objectives that are in place to fulfill this goal focus on the twelve components of the national M&E system namely: structures, capacity, partnership, M&E Plan, M&E work-plan, advocacy, routine monitoring, surveys, surveillance, research, databases, dissemination and use of information. This M&E plan contains indicators, data sources, information flow as well as roles and responsibilities of stakeholders. In order to successfully implement this plan, active participation of all stakeholders is required. The M&E Plan will provide strategic information to enable sound decision making in the national multi-sectoral response to HIV and AIDS in Liberia.

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Monrovia, December 2010

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iv. List of acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CBO	Community-based Organization
CSO	Civil Society Organization
DSW	Department of Social Welfare
FBO	Faith-based Organization
FHI	Family Health International
FSW	Female Sex Workers
GFATM	Global Fund to fight against AIDS, Tuberculosis and Malaria (or 'The Global Fund')
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ILO	International Labor Organization
LIBR	Liberia Institute for Biomedical Research
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goal
MoD	Ministry of Defense
MoE	Ministry of Education
MoF	Ministry of Finance
MoGD	Ministry of Gender and Development
MoHSW	Ministry of Health and Social Welfare
MoL	Ministry of Labor
MSM	Men who have Sex with Men
MTR	Mid-Term Review
MVC	Most Vulnerable Children (including orphans)
NASA	National AIDS Spending Assessment
LDHS	Liberia Demographic and Health Survey
LISGIS	Liberia Institute of Statistics and Geo-Information Systems
NAC	National AIDS Commission
NACP	National AIDS and STI Control Program
NSF	National HIV Strategic Framework II 2010-2014
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PRS	Poverty Reduction Strategy
SGBV	Sexual and Gender Based Violence
SGS	Second Generation Surveillance
SIM	Strategic Information Management
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

V. EXECUTIVE SUMMARY

Liberia is located along the Atlantic Ocean in West Africa and inhabited by approximately 3.5 million persons with a population growth rate of 2.1% and income per capita of LD$260. The country is divided into 15 administrative counties, while 36% of its population is composed of people ages 15-49 years. Liberia is recovering from 14 years of civil conflict which ended in 2003. The conflict displaced the population from the rural to urban areas. This civil conflict had negative impacts on economic growth, infrastructure, health systems and human resource capacity in the country. In the 1985, Liberia reported the first cases of HIV and by 2007; about 38,000 persons were living with HIV and AIDS. By 2010 HIV prevalence among women attending antenatal clinics stood at 5.4%; while prevalence among ages 15-49 reproductive age population was 1.5%, with women at 1.8% compared to men at 1.2%.

In Liberia, persons identified as most vulnerable or at risk of HIV and AIDS include the following: survivors of sexual and gender-based violence, young women and girls, female sex workers, mobile and displaced populations, clients of sex workers, men who have sex with men, men in incarceration, Infants born to HIV infected mothers, people living with HIV and AIDS, persons facing challenges in accessing HIV and AIDS services and information, orphans and most vulnerable children. However, there is a shortage of reliable data on HIV and AIDS in the country; therefore most of data used for programming is largely based on the 2007 LDHS and on small scale research and anecdotal evidence.

Several state and non-state organizations have been mobilized to control the spread and mitigate the negative impact of HIV and AIDS in Liberia. The Liberia National AIDS Commission was established by a presidential executive Order in 2000 to lead and coordinate HIV and AIDS related activities of all stakeholders in public, civil society and private sectors. In their interventions, stakeholders are guided by the National l HIV and AIDS Strategic Framework II HIV and AIDS. The first strategic framework covered the period 2004 to 2007, the second one covers 2010 to 2014.

The goals of the current strategic framework are to contain the HIV prevalence among the general population to below 1.5% by 2014 and to mitigate the impact of the epidemic on health and wellbeing of persons infected and affected by HIV and AIDS. The framework has five key action areas of focus for the national AIDS response, namely: (i) coordination and management of the national response (ii) strengthening HIV prevention (iii) scaling up coverage and quality of treatment care and support (iv) availing and using strategic information and (v) reducing stigma and discrimination.

This monitoring and evaluation plan explains and documents the system which generates strategic information to measure progress towards achieving the goals and objectives of the strategic framework. Strategic information is generated through routine monitoring, research, surveys and surveillance. Two main results are achieved by implementing this M&E Plan: (i) a strengthened and functional national M&E system being in place and (ii) accurate, strategic information available and accessible to all stakeholders, and used for evidence-informed policy and program planning, and resource allocation.

The overall goal of the national, multi-sectoral HIV and AIDS M&E system is to generate and disseminate high quality, relevant, timely, and strategic information that will guide stakeholders to improve quality, access and utilization of HIV and AIDS services.' The objectives of the M&E system in line with this goal are the following:

a. to strengthen institutional and human capacity and structures for M&E;
b. to enhance coordination and accountability among HIV and AIDS stakeholders
c. to assess the service coverage, equity and stakeholders needs for HIV and AIDS interventions within the country;
d. to provide an overview of the HIV and AIDS situation, trends in the epidemic and epidemiology, lessons learnt as well as most significant changes in the country;.
e. to collect, analyze and avail strategic information in a well-organized flow among all stakeholders in a synchronized manner;
f. to promptly disseminate and use strategic information for evidence based decision making by stakeholders.

This M&E Plan contains a foreword, acknowledgement, table of contents, list of acronyms, abbreviations and an executive summary. The plan is divided into four the following main sections:(Section 1) introduction which explains Liberia and its main HIV and AIDS issues (Section 2) background which explains the importance, relevance, goal, objectives, principles and structure of the M&E system (Section 3) what is measured by the M&E system including results, indicators, data sources, information products and stakeholders who generate report and or utilize strategic information (Section 4) how the M&E system functions is explained by elaborating each of the twelve components of the M&E system including: Organizational structures, human capacity, partnerships, work plan, advocacy, communications and culture, routine monitoring, periodic surveys and surveillance, databases, supervision and data auditing, evaluation and research and using information to improve results. (Section 5) conclusion and way forward which explains the most immediate actions to operationalize this M&E Plan.

The implementation of this M&E Plan is overseen and coordinated by National AIDS Commission in collaboration with other stakeholders. The plan was developed through consultative meetings with

stakeholders, workshops and peer review mechanisms. During the mid-term review of the National Strategic Framework, this M&E Plan will also be updated to measure progress of implementation of activities in the national HIV and AIDS response in Liberia.

SECTION 1: INTRODUCTION

1.1 DEMOGRAPHIC AND HEALTH PROFILE OF LIBERIA

Liberia is a West African country that is administratively divided into 15 counties which are further sub divided into several districts per country. The 2008 population and housing census conducted by the Government of Liberia reported a total population of approximately 3.5 million persons residing in the country. According to the Liberia Demographic and Health Survey (LDHS) of 2007, young people aged 5-14 account for 29.5% of the Liberian population, while the 36% of the population is made up of population ages 15-49 years. Liberia also hosts the United Nations military forces that are in the country for peacekeeping purposes.

Most of the Liberian population resides in the urban areas having been displaced from the rural areas due to insecurity during the 14 year civil conflict which ended in the year 2003. Urban areas report higher HIV prevalence as compared to rural areas. The population growth rate of Liberia stands at 2.1% as reported by the National HIV Strategic Framework II 2010-2014 (NSF). In 2007 LDHS also reported gross national income per capita at 260$, life expectancy birth m/f (years) was at 43/46, total expenditure on health per capita stood at 39$, infant mortality rate was 71 per 1000 live births and child mortality rates were 110 per 1000 live births.

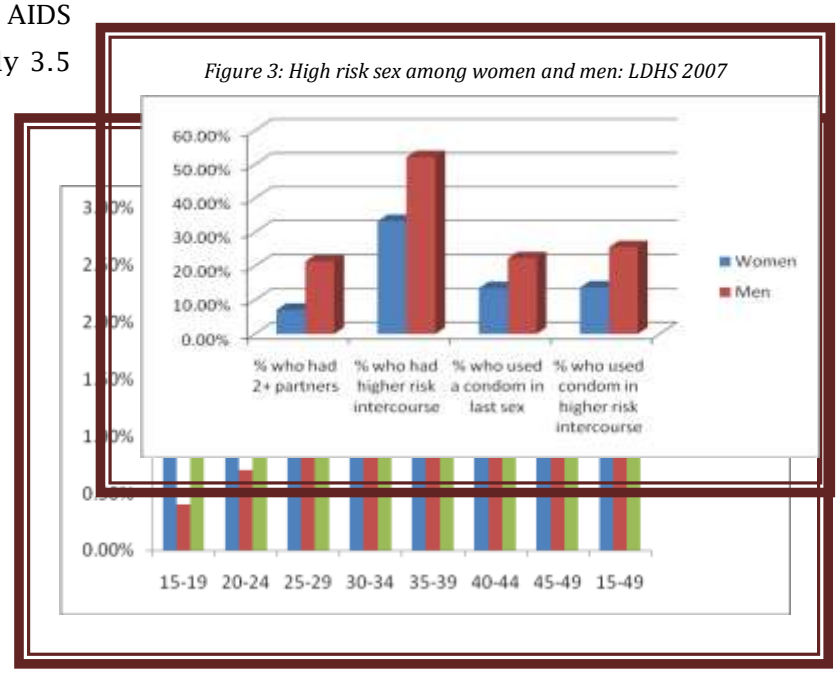
The 14 years of civil conflict in Liberia displaced population, devastated basic government institutions, destroyed physical infrastructure, weakened the public health care system and eroded the social capital as well as the country's economy. After the war, Liberia has witnessed an increase in population growth which cannot be met with the existing public health care system that is already facing financial, technological, material and human resource constraints.

Unemployment, poverty, high levels of mobility in search for income, gender inequality, sexual and gender-based violence (SGBV), flight of highly trained and skilled experts from the country are some of the major social and economic challenges facing Liberians today. Among the major health related complications in the country include HIV and AIDS, mental health problems, tuberculosis (TB) and water borne diseases.

1.2 HIV EPIDEMIOLOGY IN LIBERIA

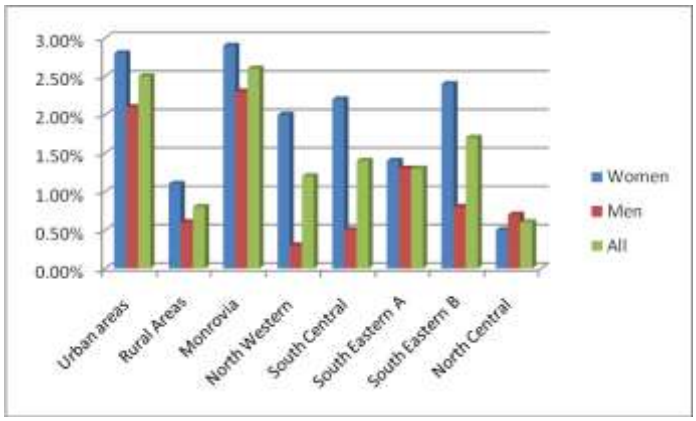
HIV was first reported in Liberia in 1985, and by 2007 the LDHS reported that a total of 36,000 Liberians were living with HIV and AIDS (PLHIV) in the country of approximately 3.5 million people. However, the NSF observes that there is scarcity and shortage of reliable data on HIV and AIDS in Liberia therefore most data used for programming is based on small on the 2007Health and Demographic Survey (Figure 1) and small scale research and anecdotal evidence.

Figure 3: High risk sex among women and men: LDHS 2007



Before 2006 HIV prevalence data was only available through routine screening of blood donors, inpatients, outpatients, TB patients, patients enrolled into prevention of mother-to-child transmission of HIV (PMTCT) services in ante natal clinics (ANC), as well as voluntary counseling and testing (VCT) clients.

Figure 2:HIV prevalence by regions, rural and urban: LDHS 2007



By 2006, the first ANC surveillance was conducted in Liberia and this was followed by the next round of ANC surveillance in 2007. Furthermore, the currently available population-based HIV prevalence data for the country was generated through the LDHS undertaken in 2007 (Figures 1&2). In 2007 the ANC surveillance conducted in 15 sites which included 2 rural sites reported 5.4% HIV prevalence among pregnant women. The LDHS reported 1.5% prevalence among age 15-49 in the general population for the same year. Within this age group the reported prevalence for women was higher at 1.8% than that of men at 1.2%.

Urban areas where the majority of Liberians reside also reported higher HIV prevalence of 2.5% as compared to rural population prevalence of 0.8%. The Eastern and Western border regions where

cross border trade, mining and sex work are predominant also registered a higher HIV prevalence as compared to other regions within the country. 21% of TB patients who underwent HIV testing were also HIV positive thus reaffirming the need for integrating HIV and TB services in the country.

Based on anecdotal evidence and small scale studies conducted within the country, the NSF suggests that poverty, gender inequality including SGBV, as well as mobility or migration for employment or trade are the three main factors which facilitate HIV risk and vulnerability in the country. Based on the available evidence, the NSF also explores that most at risk populations (MARPs) and vulnerable groups in Liberia include: Survivors of SGBV, young women and girls, female sex workers (FSW), mobile and displaced populations, clients of sex workers, men who have sex with men (MSM), men in prisons and infants born to HIV infected mothers. The LDHS 2007 notes that men engaged more in risky sexual practices as compared to women, (Figure 3:).

Referring to the small scale studies, the NSF also highlights women and children as the most vulnerable to HIV. Their main vulnerability factors listed include poverty, gender inequality and SGBV, as well as harmful traditional beliefs and practices. Populations listed in the NSF as bearing the greatest impact of HIV and AIDS include PLHIV, orphans and children made vulnerable by HIV and AIDS (MVC) as well as families which care for a relative who is living with HIV.

1.3 GROUPS WHO ARE MOST AT RISK, VULNERABLE AND NEGATIVELY IMPACTED UPON

Based on existing evidence, the following population groups are deemed to be most at risk, vulnerable or impacted upon by HIV and AIDS:

a. *Survivors of sexual and gender-based violence:* Widespread SGBV perpetrated by rebels and paramilitary during conflict and by neighbors and intimate partners during post conflict situations has remained a main challenge facing women and children in Liberia. Women have been subjected to SGBV including gang rape, sexual slavery, domestic violence and sex for survival in exchange for food and other basic means of survival. SGBV leads women and children to face risk of and vulnerability to HIV, sexually transmitted infections (STI), unwanted pregnancies, sexual and reproductive health (SRH) problems including infertility, as well as social stigma and discrimination.

b. *Young women and girls:* The NSF notes that HIV prevalence is possibly higher among young women and girls due to the following factors: SGBV, poverty, harmful traditional beliefs and practices, gender inequality, low HIV awareness rates, early age of sexual debut, high risk sexual behaviors, inconsistent condom use and weak skills to negotiate for proper and

consistent condom use. These factors place young Liberian women and girls at higher risk and vulnerability to HIV.

c. *Female Sex Workers:* Women and girls involved in sex work are noted to be at higher HIV risk and vulnerability due to the following reasons: Poverty which reduces their chances of negotiating safe sex, low access to education, sex for survival in exchange for food and other favors like employment, exploitation of sex workers and trafficking. FSW are classified in three groups of full time professional sex workers, those who offer sex for survival on an abhor basis, and those whose practices resemble transactional sex but live in their family home.

d. *Mobile and displaced populations who are mainly clients of sex workers:* While the sex workers are at risk their clients who mainly comprise of mobile men are at risk too. These mobile men include long distance truck and bus drivers, United Nations peacekeeping forces, business men and miners. In addition to buying sex from sex workers, these men may have sex with women in the general population thereby causing the bridge population between sex workers and the wider population.

e. *Men who have sex with men:* Based on a small scale qualitative study conducted in 2009, the NSF notes that MSM could be at higher risk of HIV because of prevalence of unprotected sex, history of rampant STIs, limited knowledge of HIV, and limited access to HIV services due to social rejection, stigma and discrimination.

f. *Men in prisons:* Based on anecdotal evidence, the NSF notes that another group that could be at risk of HIV is men in incarceration. These men are isolated, confined with fellow men in crowded spaces therefore engage in unprotected anal sex with fellow men. At times sexual engagement is voluntary, other moments the men may be raped by fellow men. Men in incarceration often do not access or use condoms, have lower knowledge on HIV prevention and could easily transmit HIV to their sexual partners upon their release.

g. *Infants born to HIV infected mothers:* The NSF notes that children born to women living with HIV risk infection from their parents mainly due to the collapse of the public health care system in Liberia. The health care system faces challenges in women not knowing their HIV status, mothers not seeking adequate HIV services for PMTCT, limited coverage of PMTCT and low utilization of PMTCT services by women and men. These challenges are compounded by shortage of skilled manpower, equipment, supplies and drugs required to launch an expanded PMTCT service delivery in the country.

h. *Impact of HIV and AIDS on PLHIV and MVC:* Although the HIV epidemic in Liberia is still low, there are indeed some population groups identified by the NSF as having been impacted by the epidemic including PLHIV and MVC. PLHIV and MVC face inadequate access to care, treatment and support services thereby posing a threat to their health and wellbeing. The impact of the war includes poverty with weakened systems which constrain communities' ability to cope with providing nutrition, social support and basic human supplies like food, clothing, education and income for PLHIV and MVC.

i. *PLHIV facing access challenges:* NSF reports that most PLHIV have not undergone HIV testing, therefore do not know their status and have not taken up required treatment, care and support services. Inadequate staff capacity, limited equipment or interrupted supply of test kits, reagents, anti-retroviral drugs (ART) and opportunistic infections (OI) drugs also limits access of PLHIV to HIV services. Rampant stigma and discrimination also not only poses a serious threat to psychological health but also to PLHIV and MVC access to claim their basic human rights like employment, education, treatment and other services.

1.4 NATIONAL HIV and AIDS RESPONSE IN LIBERIA

The national HIV and AIDS response has structures at national, sector, county and community levels. Within this structure there are clear roles and mandates of key public, civil society organizations (CSOs) and private sector stakeholders involved in HIV and AIDS interventions as follows:

a. *Liberia National AIDS Commission (NAC)* is the Government organ that was established in the year 2000 by a presidential executive order . The Commission leads and coordinates HIV and AIDS related activities of stakeholders from public, civil society and private sectors. More specifically the Commission undertakes: monitoring and evaluation, information sharing, building stakeholders HIV and AIDS knowledge and skills, policy review and formulation, and mobilizing resources for HIV and AIDS interventions.

b. *The Liberia Country Coordinating Mechanism (CCM)* was established in 2002 by stakeholders engaged in the Global Fund for HIV and AIDS Tuberculosis and Malaria (The Global Fund). This mechanism undertakes oversight and coordination of all The Global Fund funded projects which are in Liberia. The CCM also reviews and approves The Global Fund program proposals, plans, budgets and reports.

c. *The National Technical Working Group (TWG) for HIV and AIDS* was established in 2009 and is composed of The Commission, sectors, CSOs and international development partners.

This TWG meets every quarter to discuss HIV and AIDS achievements, concerns and challenges then makes recommendations and solutions. The technical working group also reviews plans, budgets, proposals and reports for various HIV and AIDS activities in Liberia.

d. *International Development Partners* play a significant role of mobilizing and availing the required financial, technical, material and technological resources so as to expand and strengthen interventions within the national AIDS response. The development partners work through the CCM and national technical working group.

e. *Government Ministries and Agencies* (MDAs) coordinate HIV and AIDS activities within their respective sectors. At the central level MDAs are at various stages of mainstreaming HIV and AIDS into their sector policies, strategies, work plans and budgets. Various MDAs also generate strategic information relating to HIV and AIDS within their respective sector. At sub-national levels and within the communities, some MDAs are involved in undertaking HIV and AIDS interventions in their sectors.

f. *Government Counties and Districts authorities* have mainstreamed HIV and AIDS into their strategies, work plans and budgets. These authorities also support coordination of M&E activities at their respective levels and are at times involved in undertaking HIV and AIDS information, education and communication activities.

g. *Civil society organizations* are mainly composed of faith-based organizations (FBOs), non-governmental organizations (NGOs), community-based organizations (CBOs) and private businesses which are mainly involved in implementing HIV and AIDS interventions at all levels. At the national level, umbrella CSOs, national and international CSOs focus on policy advocacy, as well as mass information, education and information. At the sub-national and community levels some CSOs directly provide HIV prevention, treatment, care and impact mitigation services.

h. *The National AIDS and STI Control Program (NACP)* plays a particularly prominent role in coordinating and delivering HIV and AIDS services within the health sector. In addition to the national level Ministry of Health and Social Welfare (MOHSW) activities, the Health Facilities are also responsible for providing HIV prevention, treatment, care, and support and impact mitigation services within the clinical settings.

i. *The national support organization of PLHIV* is responsible for coordinating activities of various support organizations and defending the rights of PLHIV. The Light Association was established in 2002 as the national umbrella organization for all networks of PLHIV. The

PLHIV support organizations are mainly responsible for policy advocacy to ensure that PLHIV claim their human rights to universal access to HIV and AIDS services.

1.5 THE NATIONAL MULTISECTORAL HIV and AIDS RESPONSE IN LIBERIA

The first multi-sectoral NSF for Liberia covered the period 2004-2007, this current second generation of the NSF II commences in 2010 and comes to an end in 2014. This NSF has listed two overall goals of the national HIV and AIDS response, namely: (a) To contain the HIV prevalence among the general population to below 1.5% by 2014 and (b) To mitigate the impact of the epidemic on health and wellbeing of persons infected and affected by HIV and AIDS.

In line with these overall goals, the NSF has listed 5 key thematic areas of focus for the national AIDS response as follows: (i) Coordination and management of the national response, (ii) Strengthening HIV prevention, (iii) Scaling up coverage and quality of treatment care and support, (iv) Availing and using strategic information and (v) Reducing stigma and discrimination.

For each thematic area, the NSF has stated an objective to operationalize the two goals. This M&E Plan therefore assigns input, output and outcome indicators to assess coverage of services and the extent to which the following NSF objectives achieved. These NSF objectives are as follows:

a. to ensure effective coordination and management of a decentralized, multisectoral and national response to HIV;
b. to reduce the number of new HIV infections among most at risk populations and vulnerable groups in the general population, with special focus on women and girls;
c. to strengthen quality, and scale up coverage and utilization of treatment, care and support for PLHIV, MVC and other affected groups;
d. to strengthen availability, sharing and utilization of strategic information that will guide the planning and implementation of policies and programs;
e. to promote a supportive environment for women, men and children living with HIV, and reduce HIV associated stigma and discrimination.

Interventions aimed at achieving the NSF objectives are implemented by CSOs as well as sector MDAs at national and also at the community levels. Funding used for implementing these interventions is mainly provided by Government and international development partners. Progress in achieving the desired NSF results and objectives are assessed through the national multi-sectoral HIV and AIDS M&E system. Progress towards achieving these NSF goals and objectives is measured through impact indicators contained in this M&E Plan. While progress in generating resources and implementing planned activities against their targets is measured through output and input indictors in this M&E Plan.

1.6 THE LIBERIAL NATIONAL MULTI-SECTORAL HIV and AIDS M&E SYSTEM

NSF reiterates the critical importance of M&E by placing strategic information management as one of the five key thematic areas of focus for the national HIV and AIDS response. The M&E system is designed to address the dire shortage of strategic information on HIV and AIDS in Liberia. The M&E system focuses on generating strategic information from the year 2010 to 2012. This strategic information will be used to review and update the NSF during the 2012 Mid Term Review (MTR) of the national HIV and AIDS response.

Research, surveys and surveillance to generate strategic information will be undertaken within the first two years. This strategic information will focus on risk, vulnerability and impact. In the initial two years, the M&E system will generate critical information on HIV risk including MARPS: prevalence, vulnerability, risk, behavioral trends, and demographic factors like size estimation, geographical locations, sexual networks, needs, service coverage and access factors. Vulnerability studies will also be conducted among women, children and other selected population sub groups. Sectoral impact studies will be commissioned to unveil the actual impact of HIV and AIDS among various population groups in various sectors.

Furthermore, on a routine basis the M&E system will also generate strategic information on HIV and AIDS. Information from the health facilities will continue to be captured and reported through the MOHSW managed Health Management Information System (HMIS). Community-based HIV and AIDS information will be centrally channeled to and reported through the Country Response Information System (CRIS) which is managed by the Liberia Institute of Statistics and Geo-Information Services (LISGIS). The routine monitoring information systems will mainly focus on needs, service coverage and some limited amounts of behavioral trends.

The main results desired from the M&E system as stated in the NSF include (a) a strengthened and functional national M&E system being in place and (b) accurate, strategic information being available and accessible to all stakeholders, and used for evidence-informed policy and program planning, and resource allocation. NSF strategies for achieving these results include: Strengthening technical capacity in the field of strategic information management among policy makers and program staff; Establishing and rolling out the national surveillance and M&E system and plan; Establishing a comprehensive national second generation surveillance (SGS) system to allow adequate monitoring of biological and behavioral trends among the general population and key populations at risk; establishing a national HIV database and disseminating HIV data and information using different formats and media; developing quality assurance and M&E tools and mechanisms to assess the effectiveness of HIV services, drugs and capacity building in the health

sector, and; conducting special research on the drivers and other underlying dynamics of the HIV epidemic; Impact assessments and other studies to inform policy and program planning.

During the 2012 MTR, the extent to which the M&E system is functional will also be assessed. In assessing the M&E system, indicators which will be applied include but are not limited to the following NSF indicators: number of organizations systematically reporting to the M&E system on an annual basis; number of publications by The Commission and NACP; total number of people trained in strategic information management and quality assurance mechanisms established and functioning. Based on the M&E system assessment findings, as well as the changes made to the NSF, this M&E plan will then be revised and updated after the MTR in 2012. The M&E plan which is aligned to the updated NSF will also cover the remaining NSF period.

SECTION 2: HOW THE M&E SYSTEM FUNCTIONS

2.1 INTRODUCTION

This section explains what the Liberia National Multi-sectoral HIV and AIDS M&E system which is documented within this Liberia National Multi-sectoral HIV and AIDS M&E Plan is all about. It justifies the necessity of having the M&E system in place and describes the M&E system goal, objectives, principles and approaches, as well as the structure of this M&E Plan. Laws, policies, strategies and information systems that relate to the M&E System are also listed. The section concludes with an explanation of M&E related mandates and authority of government and other organizations.

2.9 RATIONALE OF THE M&E SYSTEM

This national multi-sectoral M&E system generates strategic information on HIV and AIDS from all sectors. Without this M&E system, then stakeholders would not be in a position to better understand the HIV epidemic with its driving factors as well as track the trends in other co-infections like TB and other Opportunistic Infections (OIs). The absence of an M&E system would also mean stakeholders are unable to determine if their activities are on track to realize the set targets and desired results of the NSF. Last but not least, without an M&E system then stakeholders would face difficulty: in accounting for uses of resources, justifying resource gaps, setting feasible and well prioritized targets, and projecting resources and efforts required to meet the goals and objectives of the national HIV and AIDS response.

2.10 GOAL OF THE M&E SYSTEM

The overall goal of the national, multi-sectoral HIV and AIDS M&E system is to generate and disseminate high quality, relevant, timely, and strategic information that will guide stakeholders to improve quality, access and utilization of HIV and AIDS services.'

2.11 OBJECTIVES OF M&E SYSTEM

Several objectives are in place to meet the set overall goal of the national multi-sectoral HIV and AIDS M&E system. These objectives are listed as follows:

2.11.1 to strengthen institutional and human capacity and structures for M&E.

2.11.2 to enhance coordination and accountability among HIV and AIDS stakeholders;

2.11.3 to assess the service coverage, equity and stakeholders needs for HIV and AIDS interventions within the country;

2.11.4 to provide an overview of the HIV and AIDS situation, trends in the epidemic and epidemiology, lessons learnt as well as most significant changes in the country;

2.11.5 to collect, analyze and avail strategic information in a well organized flow among all stakeholders in a synchronized manner;

2.11.6 to promptly disseminate and use strategic information for evidence based decision making by stakeholders.

2.12 PRINCIPLES AND APPROACHES OF THE M&E SYSTEM

Activities within the M&E system are governed by the main principles and approaches outlined below:

a. *Aligned to the NSF.* The M&E Plan covers the period of 2010-2014 and is developed to assess progress towards goal, objectives, targets and strategies of the NSF.

b. *Developed in line with the 3-ones principles* which stipulates that every country should have: one agreed upon AIDS action framework that provides the basis for coordinating the work of all partners, one national AIDS Coordinating Authority with a broad-based multisectoral mandate, and one agreed Country level M&E system.

c. *Based on 2007 HDS and small scale research and anecdotal evidence* under the critical assumption that Liberia has an HIV prevalence of 1.5% among the general population; but with a provision to generate more strategic information for reprogramming during the 2012 MTR.

d. *Dependent upon receiving secondary data from existing structures* and information systems. This makes the system cost effective and sustainable through mainstreaming M&E into staff job descriptions, committees' mandates, policies, plans, budgets and training packages.

e. *Simple and sustainable* while developed in a systematic synchronized manner that is informed by lessons previously learnt on what works and what does not work for national multi-sectoral HIV and AIDS M&E systems.

f. *Promoting the usage of strategic information* through a national set of core indicators which responds to strategic HIV and AIDS related information needs of all stakeholders. The M&E system is inclined towards supporting stakeholders to generate, analyze, interpret and use their own localized data at the levels of the districts, counties and the country.

g. *Designed based on gender sensitive approaches* to collecting, analyzing, disaggregating and reporting data. SGBV and male participation in HIV services are also assessed by the M&E system.

h. *Meaningfully involving PLHIV in routine monitoring* for policy dialogue by assigning PLHIV strategic roles of monitoring stigma and discrimination, quality of services, as well as

coverage and access. This is done through exit interviews, telephone hotlines as well as inventories of PLHIV.

i. *Promoting mobilizing of adequate resources* for implementation of the M&E system. Stakeholders are required to mobilize adequate financial, human, material, technological and other resources necessary for the effective implementation of M&E related activities.

2.13 STRUCTURE OF THE M&E PLAN

The beginning of this M&E plan contains a foreword, acknowledgement, table of contents and List of acronyms and abbreviations. This is followed by 4 main sections of the M&E plan:

a. Section 1 which is the introduction describes the HIV and AIDS situation in Liberia, Liberia National AIDS Commission, Liberia National HIV Strategic Framework II 2010-2014 and Overview of the M&E system for HIV and AIDS in Liberia.

b. Section 2 of the plan focuses on background, importance and relevance of M&E plan. This section explains the M&E system: rationale, overall goal, objectives, principles and approaches, structure, related laws with policies and strategies, linkages to other information systems and M&E related mandates of stakeholders.

c. Section 3 contains the conceptual framework of what is being measured by the M&E system. This section has contains the results framework linked to specific objectives or results of the NSF, detailed indicator definitions and protocols and the data source matrix. The section also explains the information products and stakeholders who generate, manage or use strategic information within the M&E system.

d. The management framework of the plan is contained in section 4 which looks at the 12 components including: Organizational structures for M&E, human capacity for M&E, M&E partnerships, M&E plan, costed M&E work plan, M&E advocacy, communications and culture, routine monitoring, surveys and surveillance, databases, supervision and data auditing, evaluation and research and using information to improve results.

2.14 LAWS, POLICIES, STRATEGIES AND INFORMATION SYSTEMS THAT RELATE TO THIS M&E SYSTEM

This M&E Plan and the M&E system are guided, informed and aligned to various national and international laws, policies and strategies which are applicable in Liberia. The main laws, policies and strategies which relate to the Liberia national HIV and AIDS M&E system are as follows:

2.7.1 Government strategies

a. *The NSF:* The M&E Plan was developed to provide strategic information relating to the NSF. This M&E plan is therefore founded on measuring progress against goals, objectives, and targets outlined in the NSF. M&E system is linked to obtain primary information from HMIS, CRIS, research, survey, surveillance and program reports within the national AIDS response in the country.

b. *The Liberia Poverty Reduction Strategy (PRS):* This M&E plan is developed in sync with the Liberia National PRS which in turn is aligned to the National Development Vision. The PRS indicators which address HIV and AIDS are included in this Plan. Likewise PRS indicators which address poverty and unemployment have been adopted, adapted and included within this M&E plan. The M&E system is therefore linked to obtain and/or provide information regarding HIV and AIDS, poverty and employment from the poverty monitoring system managed by the Ministry of Planning.

c. *The National Health Policy:* Health related HIV and AIDS indicators in this plan are in line with the health policy. This M&E Plan also proposes roles, responsibilities and data flow processes in health sector in sync with the national Health Policy. The system therefore is linked to obtain and/or provide HIV related information from the HMIS as well as various program reports, research, surveys and surveillance within the health sector.

d. *MOHSW M&E strategy:* This M&E Plan is aligned to the section that addresses HIV and AIDS in the health sector as outlined in the MOHSW M&E strategy. The M&E system incorporates HIV and AIDS indicators with their respective data sources, stakeholders' roles, reporting frequency and data flow as specified in the MOHSW M&E strategy. The system therefore is linked to obtain and/or provide HIV related information from the HMIS as well as various program reports, research, surveys and surveillance within the health sector.

e. *HMIS policy and strategy:* This M&E plan is aligned to report in line with the indicators, reporting frequency, stakeholders' roles and responsibilities as well as data flow processes and monitoring tools as stipulated in the HMIS policy and strategy. The system therefore is linked to obtain and/or provide HIV related routine monitoring data from the HMIS.

f. *Blood safety policy:* This M&E plan reports information on extent of safe blood transfusion in line with the national blood safety policy and guidelines. The M&E system is therefore linked to obtain HIV related blood safety information from the MOHSW Blood Safety unit through the HMIS.

2.7.2 Other M&E systems

g. The National M&E Plan is aligned to report in line with the indicators and data sources stipulated in the Global Fund M&E plan which reports on HIV prevention, treatment, care, support, impact mitigation and systems strengthening activities. The M&E system is linked to obtain routine monitoring data from implementers of The Global Fund funded projects using the CRIS which is managed by LISGIS.

h. *UN Security Council resolutions on conflict and peace building:* This M&E plan is also aligned to generate some strategic information on HIV and AIDS pertaining to conflict and peace building operations in Liberia. The M&E Plan has adopted and adapted indicators from Resolution 1308 and other United Nations Security Council resolutions which assess HIV and AIDS in the context of conflict and peace-building. The M&E system is linked to obtain relevant data from the information system managed by the United Nations Mission (UNMIL) in Liberia.

i. *Millennium Development Goals (MDGs):* This M&E Plan has adopted and adapted indicators are aligned to the MDGs. These indicators address: poverty and hunger among PLHIV and MVC for MDG #1; primary education among MVC for MDG #2; promoting gender equality and empowerment for MDG #3; reduction of child mortality among children born of PLHIV for MDG #4 and; combating HIV and AIDS within the community for MDG #5. The M&E system is therefore linked to obtain and/or provide information from the Liberia's periodic MDG reporting system which is managed by the Ministry of Planning.

j. *United Nations General Assembly Special Session (UNGASS) declaration of commitment:* This M&E plan measures indicators contained in the UNGASS declaration of commitment which Liberia has signed up to. These indicators focus on national commitment and action, national program, knowledge and behavior and impact of HIV and AIDS interventions. The M&E system is therefore linked to obtain and/or provide information from the two yearly UNGASS country reporting system which is managed by The Commission.

k. *Convention on Elimination of Discrimination and Violence against Women (CEDAW), Convention on the Rights of the Child (CRC) and Universal Access (UA) declarations of commitment:* Some indicators in this M&E plan are developed in line with the CEDAW, CRC, UA declarations of commitment. The indicators are also aligned to the Country Operational Plan on Action for Women, Girls, Gender Equality and HIV. These indicators report on women and children's rights to non-violence, non-discrimination, treatment, care, support, food, clothing, livelihood and education. The M&E system is therefore linked to obtain and/or provide information from the systems which report on these indicators. These reporting systems are managed by Ministry of Gender and Development (MOG&D), Ministry of Education (MOE), and the Department of Social Welfare (DSW). The M&E system will also be linked to the Logistics Information Management System (LMIS) managed by Medical Stores Department to report on drug stock outs which hamper universal access to services.

l. *Greater and Meaningful involvement of PLHIV (GIPA) principles:* This M&E Plan is designed in consideration of GIPA principles which reiterate the importance of meaningfully engaging PLHIV in country HIV and AIDS processes. As a result, the M&E plan allocates a strategic role for PLHIV to monitor and report on stigma, discrimination, quality of and access to services, need for and coverage of interventions. The M&E system is therefore linked to obtain and/or provide information from the reporting system of the umbrella network of PLHIV which currently is called the Light Association.

2.15 M&E RELATED MANDATES AND AUTHORITY OF GOVERNMENT AND OTHER ORGANIZATIONS

In order for the M&E system to be fully operational, various stakeholders are responsible for performing different M&E functions from national to the community levels. These M&E related mandates have been discussed and agreed upon by stakeholders as shown in the table below:

Organization	Main M&E related mandate
a. Liberia National AIDS Commission within the Office of the President	▪ Lead stakeholders to design system and develop national multi-sectoral HIV and AIDS M&E Plan, policy, guidelines and tools ▪ Advocate with stakeholders to generate and utilize strategic information ▪ Oversee and coordinate stakeholders M&E related activities ▪ Build stakeholders technical knowledge and practical skills in M&E ▪ Manage institutional strengthening of key organizations with quality assurance for the M&E system processes and products ▪ Lead development and distribution of key information products ▪ Disseminate information generated from the M&E system ▪ Maintain an inventory and report on need for and coverage of HIV training and capacity building services for resource persons

Organization	Main M&E related mandate
	▪ Lead stakeholders through the 2012 MTR and strategic re-planning of the national multi-sectoral HIV and AIDS response
b. International Development Partners (as individual organizations or part of the CCM and national TWG)	▪ Provide technical advice to the development and implementation of the M&E plan, tools and guidelines ▪ Facilitate shared learning on effective strategies, lessons learnt and experiences on M&E systems from other countries ▪ Mobilize technical, financial, material and technological resources towards the national multi-sectoral HIV and AIDS M&E system
c. National TWG-MIS	▪ Make technical input on and formally approve the M&E Plan, policy, tools and guidelines ▪ Plan, oversee and evaluate the functionality of the M&E system ▪ Provide feedback and advice on strengthening human and institutional capacity for M&E ▪ Act as a technical think-tank for multi-sectoral HIV and AIDS M&E issues ▪ Promote monitoring, evaluation, data collection, reporting and information use among stakeholders ▪ Coordinate HIV M&E activities in their respective jurisdiction ▪ Mobilize resources for HIV M&E ▪ Review and approve research proposals
d. Government Sector Ministries	▪ Lead stakeholders in sector to design system and develop HIV and AIDS M&E section of their sector plans, policies, guidelines and tools ▪ Coordinate HIV and AIDS related M&E activities within the respective sectors including routine monitoring, research, surveys and surveillance ▪ Build technical knowledge and practical skills in M&E for sectors HIV and AIDS stakeholders ▪ Develop, distribute and disseminate HIV information products for the sector among stakeholders
e. MOHSW – NACP	▪ Lead stakeholders to design system and develop HIV and AIDS component of the health sector M&E plan, policy, guidelines and tools ▪ Coordinate HIV and AIDS related M&E activities within the health sector including routine monitoring, research, surveys and surveillance ▪ Build knowledge and practical skills in M&E for health sector stakeholders involved in HIV and AIDS interventions ▪ Develop and distribute HIV information products for the health sector ▪ Disseminate health related HIV and AIDS information among stakeholders
f. MOHSW – HMIS	▪ Obtain relevant data from health facilities and health sector agencies ▪ Audit, clean and capture routine monitoring data into the HMIS ▪ Provide data from HMIS to The Commission, NACP and other stakeholders
g. MOHSW - Department of Social Welfare	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to welfare and external support needed and provided to children, PLHIV and vulnerable groups ▪ Maintain an inventory and report on need for and coverage of community based care and support services for MVC
h. MOHSW - National reference	▪ Undertake quality assurance of HIV testing and other processes related to medical routine monitoring, research, surveys and surveillance

Organization	Main M&E related mandate
laboratory	
i. MOHSW - Blood safety unit	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to blood safety
j. MOHSW - Liberia Institute for Biomedical Research (LIBR)	▪ Provide technical support to HIV and AIDS related research, surveys and surveillance when working closely with NACP and other stakeholders
k. MOHSW - Medical Stores Department	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to drug and commodities availability and stock outs
l. MOHSW – All Health Facilities	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to prevention, treatment, care, support, impact mitigation and systems strengthening issues and services provided at health facilities
m. Liberia Institute of Statistics and Geo-Information Systems (LISGIS)	▪ Obtain relevant data from stakeholders implementing HIV and AIDS activities in communities ▪ Audit, clean and capture routine monitoring data into the CRIS ▪ Provide data from CRIS to The Commission, NACP and other stakeholders
n. Ministry of Planning	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to poverty, employment, and MDGs through the PRS monitoring system
o. Ministry of Gender and Development	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to gender equality and empowerment, gender related risk and vulnerability, SGBV, stigma and discrimination ▪ Maintain an inventory and report on need for and coverage of gender based violence survivors with basic treatment, care and support services
p. Ministry of Education	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to education sector. ▪ Maintain an inventory and report on need for and coverage of MVC with education services
q. Government Counties and Districts authorities	▪ Build knowledge and practical skills of district and county stakeholders in HIV and AIDS M&E ▪ Coordinate HIV and AIDS related M&E activities among stakeholders in districts and counties including routine monitoring, research, surveys and surveillance ▪ Develop, distribute and dissemination HIV information products on behalf of their respective district or county stakeholders
r. Umbrella CSOs and private businesses	▪ Build knowledge and practical skills of member organizations to design system and develop and implement their HIV and AIDS M&E work plans ▪ Coordinate HIV and AIDS related M&E activities among the member organizations including research, surveys, surveillance, monitoring and data collection ▪ Develop, distribute and dissemination HIV information products on behalf of their respective constituency group
s. Civil Society Organizations implementers	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to prevention, treatment, care, support, impact mitigation and systems strengthening issues and services provided by member organizations
t. Light Association and PLHIV support	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to stigma and discrimination and quality of and access to HIV and AIDS services, ▪ Maintain an inventory and report on need for and coverage of services provided to PLHIV

Organization	Main M&E related mandate
organizations	
u. Other academic and research institutions	▪ Provide support to HIV and AIDS related research, surveys and surveillance when working closely with NAC and other stakeholders ▪ Build technical knowledge and practical skills of stakeholders in all aspects of HIV and AIDS M&E

SECTION 3: WHAT IS MEASURED BY THE M&E SYSTEM

3.1 INTRODUCTION

This section contains what is being measured by the M&E Plan. The M&E system is designed based on the following four main pillars: (a) indicators which measure achievement of NSF results, (b) data sources which generate values for each of the indicators, (c) information products which are analyzed and well packaged reports containing data from the M&E system and (e) stakeholders who generate, report and/or utilize information generated from the M&E system.

This section links the M&E Plan to the NSF. The linkage is achieved by matching the desired impact, outcome, output and input level results of the NSF with their respective corresponding indicators which assess extent to which each of these NSF results are achieved. The indicators are described in a table which specifies for each indicator: The reference where it is sourced or adapted from; numerator and denominator descriptions where applicable; data sources; baseline and targets to be achieved by the end of the NSF period in 2014.

A matrix provides for each data sources: a time period covered by the data source; date when the data source should be published; frequency with which data is collected from this data source as well as; institutions responsible for managing this data source. data sources in this M&E Plan are categorized into routine data sources, episodic data sources and once-off data sources. The information product matrix placed at the end of this section specifies for each of the information product, the: name of information product; frequency of production; contents of the product; stakeholders who the product will be distributed to and; the publication date of the information product. Different roles played by various stakeholders are also described in this section.

3.2 THE NSF RESULTS FRAMEWORK

The NSF contains results which are desired to be attained by the national HIV and AIDS response at the impact, outcome, output and input levels. These results are stated as overall goals and

objectives of the NSF. This M&E Plan has listed indicators which are used to measure and report on the extent to which each of the results is achieved. For the NSF impact results, selected indicators in this M&E Plan measure the desired accomplishment of impacts at the end of the NSF period in 2014. For NSF the outcome results, certain indicators in this M&E plan measure the intermediate results which are accomplished in 2-3 years time from the commencement of the NSF in the year 2010. Regarding the NSF input and output results, this M&E plan measures immediate results accomplished after work plan activities have been implemented.

3.2.1 NSF impact results and indicators to measure accomplishments which are desired to be achieved in 5 years time

Impact results to be achieved	Impact indicators to measure whether result has been achieved
HIV prevalence contained among the general population to below 1.5% by 2014	1. HIV incidence among 15-49 2. Percentage of young women and men aged 15–24 who are HIV infected 3. Percentage of most-at-risk populations who are HIV infected
Persons infected and affected by HIV and AIDS achieve good health and well being by 2014	4. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy 5. Percentage of infants born to HIV-infected mothers who are infected

3.2.2 NSF outcome results with indicators to measure intermediate outcomes which are desired to be achieved in 2-3 years time

Outcome results to be achieved	Outcome indicators to measure whether result has been achieved
The decentralized, multi-sectoral and national response to HIV is coordinated and managed in affective manner by 2014	6. National Composite Policy Index 7. Domestic and international AIDS spending by categories and financing sources
MARPs and vulnerable groups with focus on women and girls have better access to HIV prevention services by 2014	8. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission 9. Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results 10. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results 11. Percentage of most-at-risk populations reached with HIV prevention programs 12. Percentage of schools that provided life skills-based HIV education within the last academic year
MARPs and vulnerable groups with focus on women and girls have a better understanding of how to protect themselves from HIV infection by 2014	13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission 14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Outcome results to be achieved	Outcome indicators to measure whether result has been achieved
MARPs and vulnerable groups with focus on women and girls adopt positive behavior to reduce their exposure to HIV infection by 2014	15. Percentage of young women and men who have had sexual intercourse before the age of 15 16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months 17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner 20. Percentage of injecting drug users who report the use of a condom at last sexual intercourse 21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected
PLHIV, MVC and other affected groups have better access to high quality treatment, care and support services by 2014	22. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy 23. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV 24. Current school attendance among orphans and among non-orphans aged 10–14 25. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child 26. Number of health facilities providing HIV treatment and care services in line with BPHS
Strategic information is available, shared and utilized to guide the planning and implementation of policies and programs by 2014	27. Percentage of implementing organizations reporting to the national M&E system 28. Number of information products published by The Commission and NACP using data from the national M&E system
Communities uphold human rights of and do not stigmatize or discriminate people living with or affected by HIV and AIDS by 2014	29. Percentage of women and men aged 15-49 expressing accepting attitudes towards PLHIV 30. Number of PLHIV reporting to have received free legal aid 31. Number of PLHIV support network members who volunteers or are employed in HIV and AIDS interventions

3.2.3 NSF input and output results with indicators to measure immediate results to be accomplished after work plan activities have been implemented

Input and output results to be achieved	Input and output indicators to measure whether result has been achieved
Coordination: Stakeholders work	32. Number of stakeholder coordination forums convened by The

Input and output results to be achieved	Input and output indicators to measure whether result has been achieved
together in implementing their role in the HIV and AIDS response	Commission and Counties
Policy environment: Policies are in place to guide HIV related issues in all sectors	33. Number of Government sectors with HIV and AIDS policies in place
Human resource development: Competent human resources are available to implement HIV and AIDS activities	34. Number of resource persons trained in various aspects of HIV and AIDS program planning, management, organizational development and service delivery 35. Number of resource persons trained in gender and HIV and AIDS issues 36. Total number of peer educators trained among MARPS, youth in and out of school and workplaces 37. Number of teachers trained in life skills based HIV and AIDS education 38. Number of health care staff trained in STI management 39. Number of laboratory technicians trained in blood safety guidelines 40. Number of health training institutions with HIV integrated in pre and in service training curricula 41. Total number of people trained by The Commission and NACP in strategic information management
HIV and AIDS education and communication: Vulnerable and at risk persons receive accurate information to protect themselves from HIV infection	42. Number of IEC materials distributed for free 43. Number of young people reached by life-skills based HIV/AIDS education in schools
Condoms: Male and female condoms are available for sexually active persons	44. Number of male and female condoms distributed for free
HIV workplace programs: Staff receive HIV prevention, care and support services at their workplaces	45. Number of line Ministries and Private organizations implementing HIV and AIDS work place programs 46. Number of persons reached with HIV services in the workplace programs
HIV counseling and testing: Women and men know their HIV status and are referred for care and support where need be	47. Percentage of health facilities, stand alone and mobile facilities providing HIV counseling and testing
PMTCT: Pregnant women and their partners know their HIV status and receive care and treatment where need be	48. Number of pregnant women completing HIV counseling and testing process 49. Number of pregnant women completing HIV counseling and testing process accompanied by their male partners
PEP: SGBV survivors, and those exposed to HIV through accidents or occupation receive PEP to reduce chances of infection	50. Percentage of health facilities with post exposure prophylaxis available
Blood safety: All blood and blood products are free of HIV	51. Percentage of donated blood units screened for HIV in a quality assured manner
ARV treatment: All PLHIV receive an uninterrupted ARV treatment when they need	52. Percentage of health facilities providing ARV treatment that have not experienced stock outs of first line ARV drugs for more than two weeks during the last three months
Strategic information: Strategic information is generated for decision	53. Number of special studies and surveys conducted

Input and output results to be achieved	Input and output indicators to measure whether result has been achieved
making in the national HIV and AIDS response	
Human rights: PLHIV are protected from human rights violations including SGBV, stigma and discrimination	54. Number of PLHIV reporting to have encountered sexual and gender based violence 55. Number of PLHIV reporting to have encountered stigma and discrimination in service delivery settings

3.3 LIST OF INDICATORS

Within the NSF, baseline values as well as desired target values at the end of the NSF period in 2014 have been determined for some indicators as shown in the table below. Several data sources generate values to measure achievement of NSF results through each of the NSF indicators. The table below also specifies the international or national reference that has been used to develop the indicators. Where applicable, the numerator and denominator used for calculating indicators are also described in the table. Within the table where baseline data for an indicated has not been previously collected and therefore is not available the table indicates (N/A). In cases whereby the stakeholders have not set nationally agreed upon targets for an indicator the table indicates to be determined (TBD). It is recommended that a baseline survey is undertaken to determine values of all indicators, this survey is then followed by a national planning exercise to set nationally agreed upon targets for all indicators.

Indicator	Reference	Numerator	Denominator	Data sources	Baseline	Target 2014
OVERALL GOALS						
NSF Overall goal 1: To contain the HIV prevalence rate among the general population to below 1.5% by 2014						
1. HIV incidence among 15-49	Spectrum	Total number of new HIV cases	Total number of HIV cases	0.05	N/A	0.03
2. Percentage of young women and men aged 15–24 who are HIV infected	UNGASS 22, HMIS, PRS, NSF, MDG, GFR8	Number of ANC attendees tested whose HIV test results are positive Proposed reformulation: 15-24 yrs old men and women tested positive for their HIV infection status	Number of ANC attendees tested for their HIV infection status Proposed reformulation: 15-24 yrs old men and women tested for their HIV infection status	LDHS	1.1% state year of baseline:2010	<1.0%
3. Percentage of most-at-risk populations who are HIV infected	UNGASS, NSF	Number of MARPs who test positive for HIV	Number of MARPs tested for HIV	MARPs Bio-BSS[1]	N/A	<5%
NSF Overall goal 2: To mitigate the impact of the epidemic on health and wellbeing of persons infected and affected by HIV and AIDS						
4. Percentage of adults and children with HIV	UNGASS, HMIS,	Number of adults and	Total number of adults and	HMIS	20%	50%

[1] Behavioral Surveillance Survey

known to be on treatment 12 months after initiation of antiretroviral therapy	NSF, GFR8	children who are still alive and on antiretroviral therapy at 12 months after initiating treatment	children who initiated antiretroviral therapy who were expected to achieve 12-month outcomes within the reporting period	ART cohort study (yearly)	62% (year? Source ? Check with NACP)	Target: 78% (check with NACP)
5. Percentage of infants born to HIV-infected mothers who are infected	UNGASS, NSF	Number of infants born to HIV infected mothers who are infected	Total number of children born to HIV infected mothers	Spectrum Operational study	N/A	5% should be TBD
OBJECTIVES						
NSF Objective 1: To ensure effective coordination and management of a decentralized, multi-sectoral and national response to HIV						
OUTCOME INDICATORS						
6. National Composite Policy Index (NCPI)	UNGASS, NSF	-	-	NCPI	N/A	80% up from baseline
7. Domestic and international AIDS spending by categories and financing sources	UNGASS, HMIS, NSF	-	-	NASA[2]	N/A	25%
INPUT AND OUTPUT INDICATORS						
8. Number of stakeholder coordination forums convened by The Commission and Counties	-	-	-	NAC MIS	N/A	TBD
9. Number of Government sectors with HIV and AIDS policies in place	NSF	-	-	CRIS	6	19
10. Number of resource persons trained in various aspects of HIV and AIDS program planning, management, organizational development and service delivery	NSF adapted	-	-	CRIS	N/A	TBD
11. Number of resource persons trained in gender and HIV and AIDS issues	UNAIDS[3] Gender	-	-	CRIS	N/A	TBD

[2] National AIDS Spending Assessment

	Agenda					
NSF Objective 2: To reduce the number of new HIV infections among most at risk populations and vulnerable groups in the general population, with special focus on women and girls						
OUTCOME INDICATORS						
12. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	UNGASS, NSF	Number of respondents aged 15–24 years who gave the correct answer to all five LDHS questions	Number of all respondents aged 15–24	LDHS	23.5%	70%
13. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	UNGASS, NSF	Number of MARPs respondents who gave the correct answers to all five MARPs Bio-BSS questions	Number of MARPs respondents who gave answers, including "don't know", to all five MARPs Bio-BSS questions	MARPs Bio-BSS	N/A	75%
14. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	UNGASS, HMIS, NSF	Number of HIV infected pregnant women who received ARVs to reduce the risk of MTCT in the last 12 months	Estimated number of HIV infected pregnant women in the last 12 months	HMIS	21% NACP will check for 2010	85% NACP will check
15. Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results	UNGASS, NSF, GFR8	Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results	Number of all respondents aged 15–49 including those who have never heard of HIV or AIDS	LDHS	80%	95% Target for 2014?
16. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	UNGASS, UN peace resolution, NSF adapted	Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results	Number of all respondents aged 15–49 including those who have never heard of HIV and AIDS	MARPs Bio-BSS	N/A	30%
17. Percentage of most-at-risk populations reached with HIV prevention programs	UNGASS, NSF adapted	Number of most-at-risk population respondents who	Total number of respondents surveyed	MARPs Bio-BSS	N/A	30% for

[3] Joint United Nations Programme on HIV and AIDS

		replied "yes" to both MARPs Bio-BSS questions				SW
18. Percentage of schools that provided life skills-based HIV education within the last academic year	UNGASS, NSF	Number of schools that provided life-skills based HIV education in the last academic year	Total number of schools	MOE MIS	1.5%	25%
19. Percentage of young women and men who have had sexual intercourse before the age of 15	UNGASS, NSF adapted	Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years	Number of all respondents aged 15–24 years	LDHS	W=17.2% M=8.5% (year of baseline?)	W=10% M=6% Target for 2014?
20. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	UNGASS, NSF	Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Number of all respondents aged 15–49	LDHS	W=7.1% M=21.4%	W=5% M=15% Target for 2014?
21. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	UNGASS, NSF	Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months	LDHS	W=14% M=26%	W=30% M=40% Target for 2014?
22. Percentage of female and male sex workers reporting the use of a condom with their most recent client	UNGASS, NSF	of respondents who reported that a condom was used with their last client	Number of respondents who reported having commercial sex in the last 12 months	LDHS	48%	60%
23. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	UNGASS, NSF	Number of respondents who reported that a condom was used the last time they had	Number of respondents who reported having had anal sex with a male partner	MARPs Bio-BSS	N/A	20%

		anal sex	in the last six months			
24. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	UNGASS	Number of respondents who reported that a condom was used the last time they had sex	Number of respondents who report having injected drugs and having had sexual intercourse in the last month	MARPs Bio-BSS	N/A	TBD
25. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	UNGASS	Number of respondents who report using sterile injecting equipment the last time they injected drugs	Number of respondents who report injecting drugs in the last month	MARPs Bio-BSS	N/A	TBD
OUTPUT INDICATORS						
26. Number of IEC materials distributed for free Lacks specificity and measurability Nationwide/per county	-	-	-	CRIS	N/A	TBD
27. Number of male and female condoms distributed for free	GFR8, HMIS adapted	-	-	HMIS CRIS	M=4,755,932 F=N/A	M=15,000,000 F=TBD
28. Total number of peer educators trained among MARPS, youth in and out of school and workplaces	NSF Adapted	-	-	CRIS	N/A	M&Y=650 W=3500
29. Number of young people reached by life-skills based HIV/AIDS education in schools	NSF	-	-	MOE MIS	N/A	460,000
30. Number of teachers trained in life skills based HIV and AIDS education	NSF	-	-	MOE MIS (what about community based education of teachers? Or only looking at formal education?	N/A	23,000

				Only formal)		
31. Number of line Ministries and Private organizations implementing HIV and AIDS work place programs	NSF	-	-	NAC MIS	N/A	35
32. Number of persons reached with HIV services in the workplace programs	N/A	-	-	CRIS	N/A	TBD
33. Percentage of health facilities, stand alone and mobile facilities providing HIV counseling and testing	HMIS adapted	-	-	HMIS	92	364
34. Number of pregnant women completing HIV counseling and testing process Proposed reformulation: % of pregnant women tested for HIV and knowing result	NSF, GFR8 adapted	-number of pregnant counseled and tested receiving results	number of pregnant women (estimation)	HMIS + spectrum NACP	32,518 check NACP	184,348 check NACP
35. Number of pregnant women completing HIV counseling and testing process accompanied by their male partners this indicator should be deleted	NSF, GFR8 adapted	-	-	HMIS	N/A	TBD
36. Number of health care staff trained in HIV and AIDS facility based program including STI,HCT,HCT,PMTCT and ARTS management	NSF	-	-	NACP MIS	356	996
37. Percentage of health facilities with post exposure prophylaxis available	NSF	-	-	NACP MIS	30	100
38. Number of laboratory technicians trained in blood safety guidelines	NSF	-	-	Blood Safety MIS	N/A	225
39. Percentage of donated blood units screened for HIV in a quality assured manner	UNGASS, NSF	Number of donated blood units screened for HIV in manner that (i) follow documented standard operating procedures and (ii) participate in an external quality assurance scheme	Total number of blood units donated	Blood Safety MIS	100%	100%
NSF Objective 3: To strengthen quality, and scale up coverage and utilization of treatment, care and support for PLHIV, MVC and other affected groups						
OUTCOME INDICATORS						
40. Percentage of adults and children with	UNGASS, NSF	Number of adults and	Estimated number of adults	HMIS	28%	80%

advanced HIV infection receiving antiretroviral therapy	adapted	children with advanced HIV infection who are currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocol at the end of the reporting period	and children with advanced HIV infection	spectrum	2010: 43%	2014: check NACP
41. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	UNGASS, NSF	Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment	Estimated number of incident TB cases in people living with HIV	HMIS TB incident study, NACP, NLACP	50.2%	90%
42. Current school attendance among orphans and among non-orphans aged 10–14	UNGASS, NSF	Orphans = Number of children who have lost both parents and who attend school Non orphans = Number of children both of whose parents are alive, who are living with at least one parent and who attend school	Orphans = Number of children who have lost both parents Non orphans = Number of children both of whose parents are alive who are living with at least one parent	LDHS	N/A	TBD
43. Number of health facilities providing HIV treatment and care services in line with BPHS This should be made more accurate/specific.	NSF adapted	-	-	NACP MIS	29	320
44. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child This indicator should be checked visa	UNGASS, NSF, GFR8	Number of orphaned and vulnerable children who live in households that received at least one of the four types of	Total number of orphaned and vulnerable children aged 0–17	LDHS	15%	45%

denominator and numerator. Not feasible to capture 'households received free basic external support in caring for the child'		support for each child				
OUTPUT INDICATORS						
45 Percentage of formal health training institutions with HIV integrated in pre and in service training curricula	-	Number of formal health training institutions with HIV integrated in pre and in service training curricula	Total number of formal health training institutions	NACP MIS	3	17
46. Percentage of formal health facilities providing ARV treatment that have not experienced stock outs of first line ARV drugs for more than 1 month during the last three months	GFR8, NSF adapted	Number of health facilities providing ARV treatment that have not experienced stock outs of first line ARV drugs for more than 1 month during the last three months	Total number of formal health facilities	LMIS	90%	100%
NSF Objective 4: To strengthen availability, sharing and utilization of strategic information that will guide the planning and implementation of policies and programs						
OUTCOME INDICATORS						
47. Percentage of implementing organizations reporting to the national M&E system	NSF adapted	Total number of implementing organizations reporting to the national M&E system	Total number of implementing organizations in the national AIDS response	NAC MIS	53%	100%
48. Number of information products published by The Commission and NACP using data from the national M&E system This lacks accuracy and specificity and measurability	NSF adapted	-	-	NAC MIS	N/A	TBD
OUTPUT INDICATORS						
49. Number of special studies and surveys conducted	NSF	-	-	CRIS	5	21
50. Total number of people trained by The Commission and NACP in strategic information management	NSF adapted	-	-	NAC MIS	N/A	150
NSF Objective 5: To promote a supportive environment for women, men and children living with HIV, and reduce HIV associated stigma and discrimination						
51. Percentage of women and men aged 15-49 expressing accepting attitudes towards PLHIV	NSF, UNGASS 2007	Number of women and men who report accepting	Number of all women and men aged 15-49 surveyed	LDHS	17%	40% Targe

		attitudes on all four LDHS questions	who have heard of HIV			t is too low
52. Percentage of PLHIV support network members who volunteer or are employed in HIV and AIDS interventions	PRS adapted	Number of PLHIV support network members who volunteer or are employed in HIV/AIDS interventions	Total number of PLHIV support network members	Light Association PLHIV invention and LIBNET+	N/A	TBD
OUTPUT INDICATORS						
53. Number of PLHIV reporting to have encountered sexual and gender based violence	N/A	Number of PLHIV reporting to have encountered sexual and gender based violence	Total number of PLHIV	Light Association telephone hotline And LIBNET and health facilities	N/A	TBD
54. Percentage of PLHIV reporting to have encountered stigma and discrimination in service delivery settings	N/A	Number of PLHIV reporting to have encountered stigma and discrimination in service delivery settings	Total number of PLHIV	Light Association exit interviews and LIBNET+	N/A	TBD

3.4 DETAILED INDICATOR DEFINITIONS AND PROTOCOLS

In order to guide and facilitate reporting using each of the indicators, indicator protocols are listed below. For each indicator the protocols specify: Purpose of the indicator; Data collection frequency for the indicator; Tools used to measure the indicator; Method used to measure the indicator values; as well as issues to consider during the interpretation of the indicator results.

1. HIV incidence among 15-49

Purpose	To assess progress towards reducing new HIV infection.
Data Collection Frequency	Annual.
Measurement Tools	Spectrum modeling software.
Method of Measurement	Information on this indicator is sourced at HMIS from The Commission using the spectrum modeling software. ▪ Numerator: Total number of new HIV cases. ▪ Denominator: Total number of HIV cases including those already deceased. Data on this indicator is disaggregated by sex. Also by groups, and age
Interpretation	This indicator is calculated annually based on estimates from the spectrum modeling software. Where available, parallel behavioral surveillance survey data are used to aid interpretation of trends in HIV prevalence.

2. Percentage of young women and men aged 15–24 who are HIV infected

Purpose	To assess progress towards reducing HIV infection.
Data Collection Frequency	Annual through HIV sentinel surveillance. Every 4 to 5 years through LDHS.
Measurement Tools	ANC registers in line with World Health Organization (WHO) guidelines for HIV sentinel surveillance. LDHS and/or other relevant population based surveys. Delete ANC
Method of Measurement	For sentinel surveillance, information on this indicator is sourced at HMIS from the health facilities ANC registers. This indicator is calculated by MOHSW using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas. The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time. ▪ Numerator: Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive. ▪ Denominator: Number of antenatal clinic attendees (aged 15–24) tested for their HIV infection status. Information on this indicator is also sourced at LISGIS from the LDHS report. During LDHS, a representative sample of women and men in the general population is selected and tested for HIV, thereby providing values for this indicator. Data on this indicator is disaggregated by ages 15-24 and by sex.
Interpretation	This indicator is applicable in generalized epidemics. This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. Other indicators should be used to measure of HIV prevalence among MARPs. Where available, parallel behavioral surveillance survey data should be used to aid interpretation of trends in HIV prevalence.

3. Percentage of most-at-risk populations who are HIV infected

Purpose	To assess progress on reducing HIV prevalence among MARPs.
Data Collection Frequency	Two years.
Measurement Tools	Bio-BSS surveys among MARPs using UNAIDS/WHO or Family Health International (FHI) guidelines.
Method of Measurement	Information on this indicator is sourced at LISGIS from the Bio-BSS survey report on MARPs. This indicator is calculated using data from HIV tests conducted among MARPs in the primary sentinel sites. The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time. ▪ Numerator: Number of MARPs who test positive for HIV. ▪ Denominator: Number of MARPs tested for HIV. Data on this indicator is disaggregated by sex and ages (<25/25+). Should also disaggregate between various groups of MARPs,
Interpretation	This indicator is applicable where there is a concentrated sub-epidemic within a generalized epidemic. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used.

4. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Purpose	To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy.
Data Collection Frequency	Annual.
Measurement Tools	ART survival rate forms.
Method of	Information on this indicator is antiretroviral therapy cohort analysis report form. As patients start

Measurement	antiretroviral therapy, monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at least 12 months of treatment should then be aggregated. ▪ Numerator: Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment. ▪ Denominator: Total number of adults and children who initiated antiretroviral therapy Data on this indicator is disaggregated by sex and ages (<15, 15+).
Interpretation	Using this denominator may underestimate true "survival", since a proportion of those lost to follow-up are alive. Data on survival over longer durations of treatment like 24 and 36months should be collected and reported to provide a better picture of the long-term effectiveness of antiretroviral therapy.

5. Percentage of infants born to HIV-infected mothers who are infected

Purpose	To assess progress towards eliminating MTCT.
Data Collection Frequency	Annual. Bi-annually
Measurement Tools	Spectrum HIV estimation modeling software. Operational study questionnaire
Method of Measurement	Information on this indicator is sourced at NACP through the spectrum estimation model. The indicator will be calculated by taking the weighted average of the probabilities of MTCT for pregnant women receiving and not receiving HIV prophylaxis, the weights being the proportions of women receiving and not receiving various prophylactic regimes. And PMTCT operational study Identify infants of mothers identified to be HIV+, test the child after completion of BF.
Interpretation	This indicator focuses on PMTCT through increased provision of ARV medicines.

6. National Composite Policy Index

Purpose	To assess progress in the development and implementation of national level HIV and AIDS policies, strategies and laws.
Data Collection Frequency	Every two years with index based on last 6 months preceding the UNGASS reporting period.
Measurement Tools	NCPI questionnaire.
Method of Measurement	Information on this indicator is sourced at The Commission from the two yearly UNGASS report. The questionnaire is completed by (a) conducting a desk review of relevant documents and (b) interviewing key people most knowledgeable about the topic. The questionnaire obtains information from Government officials regarding: Strategic plan; Political support; Prevention; Treatment, care and support; Monitoring and evaluation. It obtains information from civil society organizations regarding: Human rights; Civil society involvement; Prevention; Treatment, care and support. Data on this indicator is disaggregated by: Type of policy, number of policies developed, number of policies adopted, number of policies with funded work-plans and number of policies being implemented.
Interpretation	In calculating the index, it is important to ensure a process of data collection and data reconciliation between different stakeholders, detailed analysis of the responses, and usage of data in strengthening the national HIV response.

7. Domestic and international AIDS spending by categories and financing sources

Purpose	To collect accurate and consistent data on how funds are spent at the national level and where those funds are sourced.
Data Collection Frequency	Annual based on Government financial reporting year.
Measurement Tools	NASA questionnaire is the primary tool used to measure this indicator. National Health Accounts and Resource flow surveys can also be used as alternative methods.

Method of Measurement	Information on this indicator is sourced at Ministry of Finance (MOF) from the NASA report. Expenditures are classified as: Prevention; Care and treatment; Orphans and vulnerable children; Program management and administration strengthening; Incentives for human resources; Social protection and social services; Enabling environment and community development, and; Research. Financing sources are organized in three categories namely: Domestic public, International and Domestic private. Data on this indicator is disaggregated by financing sources and NSF intervention area.
Interpretation	The financial data entered in the National Funding Matrix must be actual expenditures, not budgets or commitments. The data also includes AIDS expenditures that were made as part of broader systems of service provision.

8. Number of stakeholder coordination forums convened by The Commission and Counties

Purpose	To assess strength and capacity of The Commission and Counties in coordinating the national AIDS response within their respective jurisdiction.
Data Collection Frequency	Quarterly.
Measurement Tools	The Commission and Counties monitoring reports.
Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by The Commission and Counties through CRIS. Every quarter The Commission and Counties record the number of coordination forums which they have convened as well as purpose, area and people who participated in the monitoring reports to CRIS. Data on this indicator is disaggregated by The Commission and each of the Counties.
Interpretation	The quality of forums, issues discussed and changes brought about should also be described to assess the extent to which coordination and partnership are enhanced.

9. Number of Government sectors with HIV and AIDS policies in place

Purpose	To assess progress in the development and implementation of sectoral HIV and AIDS policies, strategies and laws.
Data Collection Frequency	Quarterly.
Measurement Tools	Sectors monitoring reports.
Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by sectors through CRIS. Every quarter Government sectors report the number of HIV and AIDS policies which they have formulated and adopted as well as their purpose and desired outcomes in the monitoring reports to CRIS.
Interpretation	The main provisions of the policies and changes brought about by these provisions should be described to assess the quality of policies developed with their respective implementation status.

10. Number of resource persons trained in various aspects of HIV and AIDS program planning, management, organizational development and service delivery

Purpose	To assess progress towards increasing management and institutional capacity of organizations supporting or implementing HIV and AIDS interventions.
Data Collection Frequency	Quarterly.
Measurement Tools	Monitoring reports of all stakeholders based on training registers.
Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by Government agencies, civil society and private sector businesses. Every quarter these stakeholders report through CRIS on the number of resource persons they trained. Data on this indicator is disaggregated by Government agencies, NGOs, FBOs, CBOs and private sector businesses as well as the kind of training provided and sex.

Interpretation	The training content and people trained with how they apply training should be described so as to assess the quality of training provided.

11. Number of resource persons trained in gender and HIV and AIDS issues

Purpose	To assess progress towards increasing management and institutional capacity of organizations supporting or implementing HIV and AIDS interventions in delivering a gender sensitive HIV and AIDS response.
Data Collection Frequency	Quarterly.
Measurement Tools	Monitoring reports of all stakeholders based on training registers.
Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by Government agencies, civil society and private sector businesses. Every quarter these stakeholders report through CRIS on the number of resource persons they trained in gender and HIV and AIDS related subjects. Data on this indicator is disaggregated by Government agencies, NGOs, FBOs, CBOs and private sector businesses as well as the kind of training provided and sex.
Interpretation	The training content and people trained with how they apply training should be described so as to assess the quality of training provided.

12. **Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**

Purpose	To assess progress towards universal knowledge of the essential facts about HIV transmission among the general population.
Data Collection Frequency	Every 4 to 5 years.
Measurement Tools	LDHS and/or other relevant population based surveys.

Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS report. This indicator is constructed from responses to the following set of prompted questions, namely. (1) Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? (2) Can a person reduce the risk of getting HIV by using a condom every time they have sex? (3) Can a healthy-looking person have HIV? (4) Can a person get HIV from mosquito bites? (5) Can a person get HIV by sharing food with someone who is infected? ▪ Numerator: Number of respondents aged 15–24 years who gave the correct answer to all five questions. ▪ Denominator: Number of all respondents aged 15–24. Data on this indicator is disaggregated by males and females and ages 15–19 and 20–24 years.
Interpretation	This indicator is particularly where knowledge about HIV and AIDS is poor because it permits easy measurement of incremental improvements over time. The pre-existing high levels of knowledge should also be described.

13. **Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**

Purpose	To assess progress in building knowledge of the essential facts about HIV transmission among MARPs.
Data Collection Frequency	Every two years.
Measurement Tools	Bio-BSS surveys among MARPs.
Method of Measurement	Information on this indicator is sourced at LISGIS from the Bio-BSS survey report on MARPs. Respondents are asked the following five questions. (1) Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? (2) Can using condoms reduce the risk of HIV transmission? (3) Can a healthy-looking person have HIV? (4) Can a person get HIV from mosquito bites? (5) Can a person get HIV by sharing a meal with someone who is infected? ▪ Numerator: Number of MARPs respondents who gave the correct answers to all five questions.

	▪ Denominator: Number of MARPs respondents who gave answers, including "don't know", to all five questions. Data on this indicator is disaggregated by sex and ages (<25; 25+). And by groups of MARPs
Interpretation	This indicator is applicable in a concentrated sub-epidemic within a generalized epidemic. This indicator measures incremental improvements of knowledge over time. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used.

14. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission

Purpose	To assess progress in preventing mother-to-child transmission of HIV.
Data Collection Frequency	Data should be collected continuously at the facility level and should be aggregated monthly.
Measurement Tools	PMTCT registers provide the numerator data, while the denominator data is provided by spectrum estimation model.
Method of Measurement	Information on this indicator is sourced at HMIS through monitoring reports submitted by Health Facilities using PMTCT registers. Wherever possible, the numerator for this indicator should be disaggregated by the type of antiretroviral regimen. ▪ Numerator: Number of HIV infected pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission in the last 12 months. ▪ Denominator: Estimated number of HIV infected pregnant women in the last 12 months.
Interpretation	Where possible, the health facilities should track and report on whether the infant antiretroviral dose has been provided. The facilities should also describe the main barriers which block women from accessing PMTCT services including stigma, distance and other factors.

15. Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results

Purpose	To assess progress in implementing HIV testing and counseling among the general population.
Data Collection Frequency	Every 4 to 5 years.
Measurement Tools	LDHS and/or other relevant population based surveys; or using HIV counseling and testing registers.
Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS report or other population based surveys. Respondents are asked: 1. I don't want to know the results, but have you been tested for HIV in the last 12 months? 2. If yes: I don't want to know the results, but did you get the results of that test? ▪ Numerator: Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results. ▪ Denominator: Number of all respondents aged 15–49 including those who have never heard of HIV or AIDS. Data on this indicator is disaggregated by sex and ages 15–19, 20–24 and 25–49.
Interpretation	In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. The reasons which deter people from seeking HIV test and obtaining their results should be described.

16. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results

Purpose	To assess progress in implementing HIV testing and counseling among MARPs.
Data Collection Frequency	Every 4 to 5 years.
Measurement Tools	LDHS and/or other relevant population based surveys.
Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS report. Respondents are asked: 1. I don't want to know the results, but have you been tested for HIV in the last 12 months?

	2. If yes: I don't want to know the results, but did you get the results of that test? ▪ Numerator: Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results. ▪ Denominator: Number of all respondents aged 15–49 including those who have never heard of HIV and AIDS Data on this indicator is disaggregated by sex and ages 15–19, 20–24 and 25–49. And by groups of MARPS
Interpretation	This indicator is applicable in a concentrated sub-epidemic within a generalized epidemic. In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. The reasons which deter people from seeking HIV test and obtaining their results should be described.

17. Percentage of most-at-risk populations reached with HIV prevention programs

Purpose	To assess progress in implementing basic elements of HIV prevention programs for MARPs.
Data Collection Frequency	Every two years.
Measurement Tools	Bio-BSS surveys among MARPs.
Method of Measurement	Information on this indicator is sourced at LISGIS from the Bio-BSS survey report on MARPs. Respondents are asked the following questions: 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)? 3. Injecting drug users should be asked the following additional question: In the last twelve months, have you been given sterile needles and syringes (e.g. by an outreach worker, a peer educator or from a needle exchange program)? ▪ Numerator: Number of most-at-risk population respondents who replied "yes" to both (all

	three for injecting drug users) questions. ▪ Denominator: Total number of respondents surveyed. The set of key interventions described above should be part of a comprehensive HIV prevention program, which also includes elements such as provision of HIV prevention messages, (e.g. through outreach programs and peer education), treatment of sexually transmitted diseases, substitution therapy for injecting drug users, and others. Data on this indicator is disaggregated by each group of MARPs, sex and ages (<25/25+).
Interpretation	This indicator is applicable in a concentrated sub-epidemic within a generalized epidemic. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. A description of type of interventions and their intensity could be described to measure quality of activities.

18. Percentage of schools that provided life skills-based HIV education within the last academic year

Purpose	To assess progress towards implementation of life-skills based HIV education in all schools.
Data Collection Frequency	Annual.
Measurement Tools	MOE Monitoring reports.
Method of Measurement	Information on this indicator is sourced at LISGIS from the MOE monitoring reports to CRIS. Principals/heads of a nationally-representative sample of schools (to include both private and public schools) are briefed on the meaning of life-skills based HIV education and then are asked the following question: Within the last academic year, did your school provide at least 30 hours of life-skills training to each grade? ▪ Numerator: Number of schools that provided life-skills based HIV education in the last academic year.

	▪ Denominator: Total number of schools. For all schools combined and for primary and secondary schools separately. Data on this indicator is disaggregated by primary and secondary schools and sex.
Interpretation	The indicator provides useful information on trends in the coverage of life-skills based HIV education within schools. However, the substantial variations in the levels of school enrolment must be taken into account when interpreting (or making cross-country comparisons of) this indicator. Primary and secondary school enrolment rates for the most recent academic year should be included in the supporting information provided for this indicator.

19. Percentage of young women and men who have had sexual intercourse before the age of 15

Purpose	To assess progress in increasing the age at which young women and men aged 15–24 first have sex.
Data Collection Frequency	Every 4 to 5 years.
Measurement Tools	LDHS and/or other relevant population based surveys.
Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS reports. Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: How old were you when you first had sexual intercourse for the first time? ▪ Numerator: Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years. ▪ Denominator: Number of all respondents aged 15–24 years. Data on this indicator is disaggregated by sex and ages 15–19 and 20–24 years.
Interpretation	It is difficult to monitor change in this indicator over a short period because only individuals entering the group, i.e. those aged under 15 at the beginning of the period for which the trends are to be assessed, can influence the numerator. If the indicator is assessed every two to three years, it may be better to focus on changes in the levels for the 15–17 age group. If it is assessed every five years, the possibility exists of looking at the 15–19 age group.

20. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

Purpose	To assess progress in reducing the percentage of people who have higher-risk sex.
Data Collection Frequency	Every 4 to 5 years.
Measurement Tools	LDHS and/or other relevant population based surveys.
Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS report. Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: In the last 12 months, how many different people have you had sexual intercourse with? ▪ Numerator: Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months. ▪ Denominator: Number of all respondents aged 15–49. Data on this indicator is disaggregated by sex and ages 15–19, 20–24 and 25–49 years.
Interpretation	If people simply decrease the number of sexual partners they have, the indicator will not reflect a change, even though potentially this may have a significant impact on the epidemic spread of HIV and may be counted a program success. Additional indicators may need to be selected to capture the reduction in multiple sexual partners in general.
Purpose	To assess progress towards preventing exposure to HIV through unprotected sex with non-regular partners.
Data Collection Frequency	Every 4 to 5 years.
Measurement Tools	LDHS and/or other relevant population based surveys.
Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS report. Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: 1. In the last 12 months, how many different people have you had sexual intercourse with? If more than one, the respondent is asked: 2. Did you or your partner use a condom the last time you had sexual intercourse?

	▪ Numerator: Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex. ▪ Denominator: Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months. Data on this indicator is disaggregated by sex and ages 15–19, 20–24 and 25–49 years.
Interpretation	This indicator shows the extent to which condoms are used by people who are likely to have higher-risk sex (i.e. change partners regularly). However, the broader significance of any given indicator value will depend upon the extent to which people engage in such relationships. Thus, levels and trends should be interpreted carefully using the data obtained on the percentages of people that have had more than one sexual partner within the last year. Where possible consistent and proper use of indicators should be described.

22. Percentage of female and male sex workers reporting the use of a condom with their most recent client

Purpose	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients.
Data Collection Frequency	Every 4 to 5 years.
Measurement Tools	LDHS and/or other relevant population based surveys.
Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS report. Respondents are asked the following question: Did you use a condom with your most recent client? ▪ Numerator: Number of respondents who reported that a condom was used with their last client. ▪ Denominator: Number of respondents who reported having commercial sex in the last 12 months. Data on this indicator is disaggregated by sex and ages (<25; 25+).

Interpretation	This indicator is applicable in a concentrated sub-epidemic within a generalized epidemic. Condoms are most effective when their use is consistent, rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with clients in a specified period is subject to recall bias. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.

23. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Purpose	To assess progress in preventing exposure to HIV among men who have anal sex with a male partner.
Data Collection Frequency	Every two years.
Measurement Tools	Bio-BSS surveys among MARPs.
Method of Measurement	Information on this indicator is sourced at LISGIS from the Bio-BSS survey report on MARPs. In a behavioral survey of a sample of men who have sex with men, respondents are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships and about condom use when they last had anal sex. ▪ Numerator: Number of respondents who reported that a condom was used the last time they had anal sex. ▪ Denominator: Number of respondents who reported having had anal sex with a male partner in the last six months. Data on this indicator is disaggregated by sex and ages (<25/25+). Should not be disaggregated by sex, only age.
Interpretation	This indicator is applicable in a concentrated sub-epidemic within a generalized epidemic. A description of risk behavior in sex with women among men who have sex with both women and men should also be provided. In places where men in the subpopulation surveyed are likely to have partners of both sexes, condom use with female as well as male partners should be investigated and

	described.

24. Percentage of injecting drug users who report the use of a condom at last sexual intercourse

Purpose	To assess progress in preventing sexual transmission of HIV among injecting drug users.
Data Collection Frequency	Every two years.
Measurement Tools	Bio-BSS surveys among MARPs.
Method of Measurement	Information on this indicator is sourced at LISGIS from the Bio-BSS survey report on MARPs. Respondents are asked the following sequence of questions. 1. Have you injected drugs at any time in the last month? 2. If yes: have you had sexual intercourse in the last month? 3. If yes in answer to both 1 and 2: did you use a condom when you last had sexual intercourse? ▪ Numerator: Number of respondents who reported that a condom was used the last time they had sex. ▪ Denominator: Number of respondents who report having injected drugs and having had sexual intercourse in the last month. Data on this indicator is disaggregated by sex and ages (<25/25+).
Interpretation	This indicator is applicable in countries where injecting drug use is an established mode of HIV transmission. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used.

25. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected

Purpose	To assess progress in preventing injecting drug use-associated HIV transmission.
Data Collection Frequency	Every two years.
Measurement Tools	Bio-BSS surveys among MARPs.
Method of Measurement	Information on this indicator is sourced at LISGIS from the Bio-BSS survey report on MARPs. Respondents are asked the following questions. 1. Have you injected drugs at any time in the last month? 2. If yes: The last time you injected drugs, did you use a sterile needle and syringe? ▪ Numerator: Number of respondents who report using sterile injecting equipment the last time they injected drugs. ▪ Denominator: Number of respondents who report injecting drugs in the last month. Data on this indicator is disaggregated by sex and ages (<25/25+).
Interpretation	This indicator is applicable where injecting drug use is an established mode of HIV Transmission. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used.

26. Number of IEC materials distributed for free

Purpose	To assess progress towards universal knowledge of the essential facts about HIV transmission by use of IEC materials.
Data Collection Frequency	Quarterly.
Measurement Tools	Monitoring reports of all stakeholders.
Method of	Information on this indicator is sourced at LISGIS through monitoring reports submitted by

Measurement	Government agencies, civil society and private sector businesses. Every quarter these stakeholders report through CRIS on the number of IEC materials which they have distributed to end users. Data on this indicator is disaggregated by Government agencies, NGOs, FBOs, CBOs and private sector businesses as well as the kind of training provided.
Interpretation	The focus of messages communicated and targets of the messages should be described in this indicator, as well as changes brought about by the IEC materials.

27. Number of male and female condoms distributed for free

Purpose	To assess progress towards utilization of condoms in preventing HIV transmission among sexually active population.
Data Collection Frequency	Quarterly.
Measurement Tools	Monitoring reports of all stakeholders using three main tools: OPD register for prevention, FP register for contraceptives and Community based HIV prevention service update form for prevention.
Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by Government agencies, civil society and private sector businesses. Every quarter these stakeholders report through CRIS on the number of condoms materials which they have distributed to end users. Data on this indicator is disaggregated by male and female condoms distributed.
Interpretation	An investigation should be undertaken and reported on whether these condoms are actually used and used in a proper and consistent manner.

28. Total number of peer educators trained among MARPS, youth out of school and workplaces

Purpose	To assess progress towards reaching young people with life skills based HIV and AIDS education.
Data Collection Frequency	Quarterly.

Measurement Tools	Monitoring reports of all stakeholders based on training registers.
Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by Government agencies, civil society and private sector businesses. Every quarter these stakeholders report through CRIS on the number of peer educators they have trained. Data on this indicator is disaggregated by peer educators among MARPs, youth in school and youth out of school as well as sex.
Interpretation	A description of how the peer educators are applying their training should also be provided.

29. Number of young people reached by life-skills based HIV/AIDS education in schools

Purpose	To assess progress towards reaching young people with life skills based HIV and AIDS education in schools.
Data Collection Frequency	Quarterly.
Measurement Tools	MOE Monitoring reports.
Method of Measurement	Information on this indicator is sourced at LISGIS from the MOE monitoring reports to CRIS. Principals/heads of a nationally-representative sample of schools (to include both private and public schools) are briefed on the meaning of life-skills based HIV education and then are asked how many students in their school were reached with life skills education. Data on this indicator is disaggregated by primary vs secondary schools, public vs private schools as well as by girls and boys.
Interpretation	A description of changes in knowledge and behavior of students reached with life skills education should be provided to assess quality of education.

30. Number of teachers trained in life skills based HIV and AIDS education

Purpose	To assess progress towards increasing knowledge and skills of teachers to train students in life skills education.
Data Collection Frequency	Quarterly.
Measurement Tools	MOE Monitoring reports based on training registers.
Method of Measurement	Information on this indicator is sourced at LISGIS from the MOE monitoring reports to CRIS. Principals/heads of a nationally-representative sample of schools (to include both private and public schools) are briefed on the meaning of life-skills based HIV education and then are asked how many teachers have been trained in life skills based HIV and AIDS education. Data on this indicator is disaggregated by primary vs. secondary schools, public vs. private schools as well as by sex.
Interpretation	A description of the extent to which trained teachers are in turn transferring their knowledge and skills to children should be provided to assess quality or positive outcomes of the education.

31. Number of line Ministries and Private organizations implementing HIV and AIDS work place programs

Purpose	To assess progress towards availing HIV prevention services in public and private sector workplaces.
Data Collection Frequency	Quarterly.
Measurement Tools	Ministry of Labor (MOL) Monitoring reports.
Method of Measurement	Information on this indicator is sourced at LISGIS from the MOL monitoring reports to CRIS. MOL retains an inventory of workplaces which are providing HIV and AIDS services in line with MOL/International Labor Organization (ILO) policy on workplace HIV program. Data on this indicator is disaggregated by public and private sector workplaces.
Interpretation	A description of services provided through the HIV and AIDS work place programs should also be provided so as to measure quality of work place programs implemented.

32. Number of persons reached with HIV services in the workplace programs

Purpose	To assess progress towards increasing availability of HIV prevention services in public and private sector workplaces.
Data Collection Frequency	Quarterly.
Measurement Tools	MOL Monitoring reports.
Method of Measurement	Information on this indicator is sourced at LISGIS from the MOL monitoring reports to CRIS. MOL retains an inventory of workplaces which are providing HIV and AIDS services in line with MOL/ILO policy on workplace HIV program. Data on this indicator is disaggregated by public and private sector workplaces, as well as type of service provided and by sex.
Interpretation	A description of services provided through the HIV and AIDS work place programs should also be provided so as to measure quality of work place programs implemented.

33. Percentage of health facilities, stand alone and mobile facilities providing HIV counseling and testing

Purpose	To assess progress towards increased coverage and utilization of HCT services in health care, stand alone and mobile facilities.
Data Collection Frequency	Quarterly.
Measurement Tools	NACP monitoring reports.
Method of Measurement	Information on this indicator is sourced at HMIS through monitoring reports submitted by NACP. ▪ Numerator: Total number of health facilities providing HIV counseling and testing services. ▪ Denominator: Total number of health facilities. Data on this indicator is disaggregated by health facilities, stand alone and mobile facilities.
Interpretation	An estimation of the number of people reached with counseling and testing services should also be described.

34. Number of pregnant women completing HIV counseling and testing process

Purpose	To assess progress towards increased coverage and utilization of PMTCT services as an integrated part of reproductive health care.
Data Collection Frequency	Quarterly. Monthly
Measurement Tools	ANC registers. PMTCT testing registry Spectrum
Method of Measurement	Information on this indicator is sourced at HMIS from the health facilities using ANC registers. These registers record women who come into ANC clinic as well as those who are counseled and tested for HIV. Using PMTCT testing registry
Interpretation	A description of women who are referred for other services after counseling and testing could also be provided.

35. Number of pregnant women completing HIV counseling and testing process accompanied by their male partners – the group proposed that this indicator should be deleted (get justification from NACP)

Purpose	To assess progress towards increased coverage and utilization of gender sensitive PMTCT services as an integrated part of reproductive health care.
Data Collection Frequency	Quarterly.
Measurement Tools	ANC registers.
Method of Measurement	Information on this indicator is sourced at HMIS from the health facility ANC registers. These registers record women who come into ANC clinic as well as those who are counseled and tested for HIV. The registers also indicate women who are accompanied by their male partners.

Interpretation	A description of women who are referred for other services after counseling and testing could also be provided.

36. Number of health care staff trained in STI management

Purpose	To assess progress towards strengthening capacity of syndromic STI management in accordance with national standards.
Data Collection Frequency	Quarterly.
Measurement Tools	NACP monitoring reports based on training registers.
Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by NACP. Every quarter NACP reports through CRIS on the number of resource persons they trained in syndromic STI management in accordance with national standards. Data on this indicator is disaggregated by sex.
Interpretation	Although the indicator measures the number of resource persons trained, it does not report on quality of the training or changes brought about by the training activities.

37. Percentage of health facilities with post exposure prophylaxis available

Purpose	To assess progress towards increasing availability of PEP to minimize probability of HIV infections among survivors of SGBV at health facilities.
Data Collection Frequency	Quarterly.
Measurement Tools	NACP monitoring reports.
Method of Measurement	Information on this indicator is sourced at HMIS through monitoring reports submitted by NACP. ▪ Numerator: Total number of health facilities providing PEP. ▪ Denominator: Total number of health facilities.
Interpretation	A description of the extent to which PEP reduces possibility of HIV infection should be described.

38. Number of laboratory technicians trained in blood safety guidelines

Purpose	To assess progress in increasing capacity in blood transfusion system for safe handling of blood and blood products.
Data Collection Frequency	Quarterly.
Measurement Tools	National Blood Safety Program monitoring reports based on training registers.
Method of Measurement	Information on this indicator is sourced at HMIS through monitoring reports submitted by the National Blood Safety Program. These reports are submitted to HMIS on a quarterly basis. Data on this indicator is disaggregated by sex.
Interpretation	The training content and people trained with how they apply training should be described so as to assess the quality of training provided.

39. Percentage of donated blood units screened for HIV in a quality assured manner

Purpose	To assess progress in screening of blood donations in a quality-assured manner that reduces HIV infection through blood transfusion or usage of blood products.
Data Collection Frequency	Quarterly.
Measurement Tools	Framework for Assessment, Monitoring and Evaluation of blood transfusion services (Frame tool) used by the Liberia National Blood Safety program for reporting to the WHO Global Database on Blood Safety.
Method of Measurement	Information on this indicator is sourced at National Blood Safety Program from the periodic report to WHO. The information includes (i) The total number of blood units that were donated in the country (ii) For each blood centre and blood screening laboratory that screens donated blood for HIV (iii) The number of units of blood donated in each blood centre/ blood screening laboratory (vi) The number of donated units screened in the blood centre/blood screening laboratory (v) If the blood centre/blood screening laboratory followed documented standard operating procedures for HIV screening (vi) If the blood centre/blood screening laboratory participated in an External Quality Assessment Scheme for HIV screening. ▪ Numerator: Number of donated blood units screened for HIV in manner that (i) follow documented standard operating procedures and (ii) participate in an external quality assurance scheme. ▪ Denominator: Total number of blood units donated.
Interpretation	The Liberia National Blood Safety program provides data to the WHO Global Database on Blood Safety on this indicator annually.

40. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

Purpose	To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection.
Data Collection Frequency	Quarterly. Reported for the last quarter of the reporting year. Monthly
Measurement Tools	Numerator data is sourced from ART registers while the denominator data is sourced from spectrum model.
Method of Measurement	Information on this indicator is sourced at HMIS from the health facility using the ART registers and spectrum model at NACP. ▪ Numerator: Number of adults and children with advanced HIV infection who are currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period. ▪ Denominator: Estimated number of adults and children with advanced HIV infection. Data on this indicator is disaggregated by sex and ages (<15, 15+).
Interpretation	A description of the different forms of antiretroviral therapy provided or a measure the cost, quality or effectiveness of treatment could be provided.

41. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

Purpose	To assess progress in detecting and treating TB in people living with HIV.
Data Collection Frequency	Data should be collected continuously at the facility level then aggregated monthly and quarterly.
Measurement Tools	Facility antiretroviral therapy registers and reports; program monitoring tools. ART report, TB incident study
Method of Measurement	Information on this indicator is sourced at HMIS from the health facility ART registers. Program data and estimates of incident TB cases in people living with HIV. ▪ Numerator: Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB program guidelines), within the reporting year. ▪ Denominator: Estimated number of incident TB cases in people living with HIV. Annual estimates of the number of incident TB cases in people living with HIV in high TB burden countries are calculated by WHO. Data on this indicator is disaggregated by sex by sex and by adults (>15 years) and children (<15 years).
Interpretation	This indicator provides a measure of the extent to which collaboration between the national TB and HIV programs is ensuring that people with HIV and TB disease are able to access appropriate treatment for both diseases. However, factors like low uptake of HIV testing, poor access to HIV care services and antiretroviral therapy, and poor access to TB diagnosis and treatment should be considered when interpreting this indicator.

42. Current school attendance among orphans and among non-orphans aged 10–14

Purpose	To assess progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans.
Data Collection Frequency	Every 4 to 5 years.
Measurement Tools	LDHS and/or other relevant population based surveys.
Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS report. For every child aged 10–14 living in a household, a household member is asked: (1) Is this child's natural mother still alive? If yes, does she live in the household? (2) Is this child's natural father still alive? If yes, does he live in the household? (3) Did this child attend school at any time during the school year? Part A: Current school attendance rate of orphans aged 10–14 ▪ Numerator: Number of children who have lost both parents and who attend school. ▪ Denominator: Number of children who have lost both parents. Part B: Current school attendance rate of children aged 10–14 both of whose parents are alive and who live with at least one parent. ▪ Numerator: Number of children both of whose parents are alive, who are living with at least one parent and who attend school. ▪ Denominator: Number of children both of whose parents are alive who are living with at least one parent. Data on this indicator is disaggregated by sex.
Interpretation	Typically, the data used to measure this indicator are taken from household-based surveys. Children not recorded in such surveys, e.g. those living in institutions or on the street, generally are more disadvantaged and are more likely to be orphans. Thus, the indicator will tend to understate the relative disadvantage in educational attendance experienced by orphaned children.

43. Number of health facilities providing HIV treatment and care services in line with BPHS

Purpose	To assess progress towards health systems strengthening to scale up high quality HIV treatment and care services in line with the Basic Package of Health Services (BPHS).
Data Collection Frequency	Quarterly.
Measurement Tools	NACP monitoring reports.
Method of Measurement	Information on this indicator is sourced at HMIS through monitoring reports submitted by NACP.
Interpretation	This indicator should be interpreted when considering the numbers of people who receive treatment and care services.

44. Number of health training institutions with HIV integrated in pre and in service training curricula

Purpose	To assess progress towards health systems strengthening to scale up high quality HIV treatment and care services in line with the Basic Package of Health Services (BPHS).
Data Collection Frequency	Quarterly.
Measurement Tools	NACP monitoring reports.
Method of Measurement	Information on this indicator is sourced at HMIS through monitoring reports submitted by NACP.
Interpretation	A description of persons trained using these curricula should be provided.

45. Percentage of health facilities providing ARV treatment that have not experienced stock outs of first line ARV drugs for more than 1 month during the last three months

Purpose	To assess progress towards increased coverage, utilization and universal access for PLHIV to ARV treatment.
Data Collection Frequency	Quarterly.
Measurement Tools	LMIS reports based on health facility stock cards and drug consumption books.
Method of Measurement	Information on this indicator is sourced at HMIS from the Health Facilities reports to LMIS. These reports monitor medicines and supplies in health facilities.
Interpretation	The estimated number people who do not access treatment as a result of stock outs should also be provided.

46. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child

Purpose	To assess progress in providing support to households that are caring for orphaned and vulnerable children aged 0–17.
Data Collection Frequency	Every 4 to 5 years.

Measurement Tools	LDHS and/or other relevant population based surveys.
Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS report. After all orphaned and vulnerable children aged 0–17 in the house have been identified, the household heads are asked the following four questions about the types and frequency of support received, and the primary source of the help for each orphan and vulnerable child. Each question is to be asked for each child. (1) Has this household received medical support, including medical care and/or medical care supplies, within the last 12 months? (2) Has this household received school-related assistance, including school fees, within the last 12 months? (3) Has this household received emotional/psychological support, including counseling from a trained counselor and/or emotional/ spiritual support or companionship within the last three months? (4) Has this household received other social support, including socioeconomic support (e.g. clothing, extra food, financial support, shelter) and/or instrumental support (e.g. help with household work, training for caregivers, childcare, legal services) within the last three months? External support is defined as free help coming from a source other than friends, family or neighbors unless they are working for a community-based group or organization. ▪ Numerator: Number of orphaned and vulnerable children who live in households that received at least one of the four types of support for each child (answered "yes" to at least one of questions 1, 2, 3 and 4). ▪ Denominator: Total number of orphaned and vulnerable children aged 0–17. An orphan is defined as a child below the age of 18 that has lost one or both parents. A child made vulnerable by HIV is below the age of 18 and: (i) has lost one or both parents; or (ii) has a chronically ill parent (regardless of whether the parent lives in the same household as the child); or (iii) lives in a household where, in the last 12 months, at least one adult died and was sick for three of the four months before he or she died; or (iv) lives in a household where at least one adult was seriously ill for at least three of the past 12 months. Data on this indicator is disaggregated by sex.
Interpretation	This indicator should only be monitored in areas with high HIV prevalence (5% or greater). Additional questions could be added to measure expressed needs of families caring for orphans.

47. Percentage of implementing organizations reporting to the national M&E system

Purpose	To assess progress towards having a strengthened and functional M&E system in place.
Data Collection Frequency	Annual. Quarterly
Measurement Tools	The Commission monitoring reports section on list of reports submitted.
Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by The Commission. This indicator is calculated as follows: ▪ Numerator: Total number of implementing organizations reporting to the national M&E system ▪ Denominator: Total number of implementing organizations in the national AIDS response
Interpretation	A description of the quality and timeliness of reports submitted should also be provided.

48. Number of information products published by The Commission and NACP using data from the national M&E system

Purpose	To assess progress towards availing and using strategic information to inform policy formulation, program planning and resource allocation.
Data Collection Frequency	Annual. Quarterly
Measurement Tools	The Commission monitoring reports.

Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by The Commission.
Interpretation	A description of the quality, timeliness and contents of each information product should also be provided.

49. Number of special studies and surveys conducted

Purpose	To assess progress towards increased availability and access to HIV and AIDS information to support decision making in the national AIDS response.
Data Collection Frequency	Annual.
Measurement Tools	The Commission monitoring reports.
Method of Measurement	Information on this indicator is sourced at LISGIS through studies and surveys reports whose data is captured in CRIS.
Interpretation	A description of the quality, timeliness, relevance, contents and utilization of each study and survey should also be provided.

50. Total number of people trained by The Commission and NACP in strategic information management

Purpose	To assess progress towards increasing skills among M&E staff in key government institutions and NGOs in strategic information management.
Data Collection Frequency	Quarterly.
Measurement Tools	The Commission monitoring reports based on training registers.

Method of Measurement	Information on this indicator is sourced at LISGIS through monitoring reports submitted by The Commission. Data on this indicator is disaggregated by sex.
Interpretation	The training content and people trained with how they apply training should be described so as to assess the quality of training provided.

51. Percentage of women and men aged 15-49 expressing accepting attitudes towards PLHIV

Purpose	To assess progress towards building accepting societal attitudes towards PLHIV with reduction of stigma in all settings.
Data Collection Frequency	4-5 years
Measurement Tools	LDHS and/or other relevant population based surveys.
Method of Measurement	Information on this indicator is sourced at LISGIS from the LDHS report. Survey respondents who have heard of HIV are asked a series of questions as follows: (1) If a member of your family became sick with AIDS virus, would you be willing to care for him or her in your household? (2) If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from him or her? (3) If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school? (4) If a member of your family has become infected with the AIDS virus, would you want it to remain secret? ▪ Numerator: Number of women and men who report accepting attitudes on all four questions ▪ Denominator: Number of all women and men aged 15-49 surveyed who have heard of HIV Data on this indicator is disaggregated by sex.
Interpretation	Data reported on this indicator should be verified based on feedback from PLHIV support groups since there is a possibility of bias from respondents.

52. Number of PLHIV reporting to have received free legal aid

Purpose	To assess progress towards providing a supportive legal and policy environment for PLHIV, OVC and

	others affected by HIV and AIDS.
Data Collection Frequency	Annual.
Measurement Tools	Light Association PLHIV inventory and registers.
Method of Measurement	Information on this indicator is sourced at the PLHIV inventory maintained at the Light Association. These reports are submitted to CRIS. Data on this indicator is disaggregated by sex and nature of legal support provided.
Interpretation	A description of the legal issues that were addressed and type of support provided should be provided.

53. Number of PLHIV support network members who volunteers or are employed in HIV and AIDS interventions

Purpose	To assess progress towards greater and meaningful involvement of PLHIV as a result of communities, local leaders and staff at workplace being sensitized on stigma and discrimination.
Data Collection Frequency	Annual.

Measurement Tools	Light Association PLHIV inventory and registers.
Method of Measurement	Information on this indicator is sourced at Light Association inventory. These reports are submitted to CRIS. Data on this indicator is disaggregated by sex by sex, and area of employment in: MDA, CSOs (NGO, FBO, and CBO), Private sector, Health facilities and Community outreach program.
Interpretation	This indicator should be reported with an explanation of the type of profession and sector of employment.

54. Number of PLHIV reporting to have encountered sexual and gender based violence

Purpose	To assess progress towards improving societal attitudes and reducing violence targeting PLHIV.
Data Collection Frequency	Quarterly.
Measurement Tools	Light Association free telephone hotline.
Method of Measurement	Information on this indicator is sourced at Light Association free telephone hotline. These reports are submitted to CRIS. Data on this indicator is disaggregated by sex and nature of violence reported.
Interpretation	This indicator should be reported with an explanation of the type of SGBV as well as the people who perpetrate SGBV.

55. Number of PLHIV reporting to have encountered stigma and discrimination in service delivery settings

Purpose	To assess progress towards sensitizing societies and reducing stigma and discrimination targeting PLHIV in health care setting.
Data Collection	Quarterly.

Frequency	
Measurement Tools	Light Association exit interviews.
Method of Measurement	Information on this indicator is sourced at Light Association through exit interviews. These reports are submitted to CRIS. Data on this indicator is disaggregated by sex and nature of stigma and discrimination reported.
Interpretation	This indicator should be reported with an explanation of the type of stigma and discrimination as well as the people who perpetrate stigma and discrimination.

3.5 DATA SOURCES FOR THE M&E SYSTEM

One data source can generate values for several indicators. The table below explains: The time period for which the data source generates information; Date when information generated from the data source should be published; Frequency with which data should be collected and reported from the data source as well as the; Institutions which are primarily responsible from managing data collection and reporting for each data source. The data sources are classified into: Data sources which routinely monitor and report data; Episodic data sources which generate data over periodic intervals and; Once off data sources which generate data through special research and studies commissioned in the national HIV and AIDS response.

Data source	Time period covered by data source	Publication date	Frequency of data collection	Institutional responsibility
ROUTINE DATA SOURCES				
a. Spectrum estimation model	July 1st to June 30th	July 31st	Annual	NACP
b. LDHS	Survey data collection period	2 months after completing data collection	4 to 5 years	LISGIS
c. MARPs Bio-BSS	Survey data collection period	2 months after completing data collection	Every 2 years	LISGIS
d. NCPI	6 months preceding UNGASS reporting	2 months after completing data collection	Every 2 years	NAC
e. NASA	July 1st to June 30th	July 31st	Annual	MOF
EPISODIC DATA SOURCES				
f. CRIS	July 1st to June 30th	1 month after end of reporting quarter	Quarterly	LISGIS
g. HMIS	July 1st to June 30th	1 month after end of reporting quarter	Quarterly	HMIS unit
h. NAC MIS	July 1st to June 30th	1 month after end of reporting quarter	Quarterly	NAC

i. MOE MIS	July 1st to June 30th	1 month after end of reporting quarter	Quarterly	MOE
j. NACP MIS	July 1st to June 30th	1 month after end of reporting quarter	Quarterly	NACP
k. Blood Safety MIS	July 1st to June 30th	1 month after end of reporting quarter	Quarterly	Blood safety program
l. Light Association telephone hotline	July 1st to June 30th	1 month after end of reporting quarter	Quarterly	Light Association July 1st to June 30th n
m. Light Association exit interviews	July 1st to June 30th	1 month after end of reporting quarter	Quarterly	Light Association
n. Light Association PLHIV database	July 1st to June 30th	1 month after end of reporting quarter	Quarterly	Light Association
ONCE OFF DATA SOURCES (RESEARCH AND EVALUATION)				
o. Drivers of the epidemic	Past two years	2 months after completion of study	Once off	NAC/NACP
p. Universal access to HIV services	Period of study	2 months after completion of study	Once off	NAC/NACP
q. Gender and HIV and AIDS	Past two years	2 months after completion of study	Once off	NAC, MoGD
r. Men's involvement in HIV and AIDS interventions	Period of study	2 months after completion of study	Once off	NAC, MoGD
s. Services provision	Past two years	2 months after completion of study	Once off	NAC/NACP
t. MARPS and vulnerable groups	Past two years	2 months after completion of study	Once off	NAC/NACP
u. Impact of Behavior change communication	Past two years	2 months after completion of study	Once off	NAC/NACP
v. Modes of transmission	Period of study	2 months after completion of study	Once off	NAC/NACP
w. Condom use	Past two years	2 months after completion of study	Once off	NAC/NACP
x. Traditional practices	Past two years	2 months after completion of study	Once off	NAC/NACP
y. Adolescents' risk and vulnerability studies	Past two years	2 months after completion of study	Once off	NAC/NACP

z. Effectiveness of VCT and Provider Initiated Counseling and Testing (PITC)	Past two years	2 months after completion of study	Once off	NACP
aa. Male circumcision and HIV and AIDS	Past two years	2 months after completion of study	Once off	NACP
bb. Impact of HIV and AIDS	Past five years	2 months after completion of study	Once off	NAC
cc. Nutrition and HIV and AIDS	Period of study	2 months after completion of study	Once off	NACP
dd. Adherence to treatment	Past two years	2 months after completion of study	Once off	NACP
ee. Burden of care	Past two years	2 months after completion of study	Once off	NAC
ff. OVC situation analysis	Past two years	2 months after completion of study	Once off	NAC
gg. PLHIV situation analysis	Past two years	2 months after completion of study	Once off	NAC
hh. Experiences and lessons	Past one year	2 months after completion of study	Once off	NAC
ii. Stigma and discrimination	Period of study	2 months after completion of study	Once off	NAC
jj. Baseline survey to determine indicator values and set targets	2011	1 month after completion of survey	Once off	NAC, NACP
kk. Joint mid-term review of the NSF	2010-2012	2 months after completion of the review	Once off	NAC and all stakeholders
ll. Joint end-term review of the NSF	2012-2014	2 months after completion of the review	Once off	NAC and all stakeholders

3.6 INFORMATION PRODUCTS FOR THE M&E SYSTEM

The information generated from data sources are analyzed, interpreted and packaged into interesting to read information products. These information products present data in a manner that makes it easy to interpret and apply in making decisions during policy formulation, resource allocation as well as planning and implementing programs in line with the desired results of the NSF. The table below contains a list of the information products, frequency with which each product should be produced, the main contents of information products, audience who should receive the information product as well as date when they should be published. Information products are disseminated through various channels which include the NAC and other organizations websites, The Commission and other stakeholders' resource centers, email communication, physical delivery and stakeholders' dissemination workshops.

Name of information product	Frequency	Contents	Distributed to	Publication date
a) Quarter brochure	Quarterly	• Key highlights of achievements of national response • Main recommended actions to strengthen national response	All HIV and AIDS stakeholders including: • Sector Ministries • Civil society organizations • Private sector agencies • Parliament and Cabinet • NAC Commissioners • International Development partners	One month after the end of the quarter
b) Six months coverage reports	Half yearly	• Main activities that transpired in the AIDS response • Data on achievements against all input and output indicators • Main challenges faced in achieving desired output and input results • Main recommendations to strengthen achievement of	All HIV and AIDS stakeholders including: • Sector Ministries • Civil society organizations • Private sector agencies • International Development partners	One month after the end of the half year

		output and input results		
c) Annual newsletter	Annual	• Local and international news update relating to HIV and AIDS • Calendar of HIV and AIDS events locally and internationally • Main activities that transpired in the HIV and AIDS response • Achievements, lessons learnt, best practices and challenges in the national HIV and AIDS response	All HIV and AIDS stakeholders including: • Sector Ministries • Civil society organizations • Private sector agencies • Parliament and Cabinet • NAC Commissioners • International Development partners	Two months after the end of the year
d) Annual HIV and AIDS reports	Annual	• Main activities that transpired in the AIDS response • Data on achievements against all the NSF input, output, outcome and impact indicators • Main challenges faced in achieving desired NSF results • Main recommendations to strengthen achievement of desired results • Report on the status of the M&E system • Financial report	All HIV and AIDS stakeholders including: • Sector Ministries • Civil society organizations • Private sector agencies • Parliament and Cabinet • NAC Commissioners • International Development partners	Two months after the end of the year
e) Two year UNGASS report	Two yearly	• Data on achievements against all UNGASS indicators • Main challenges faced in achieving results measured	All HIV and AIDS stakeholders including: • United Nations General Assembly Special Session on HIV and AIDS • International	Reporting period as specified in the two yearly UNGASS reporting requirements

		through UNGASS indicators • Main recommendations to strengthen the national HIV and AIDS response	Development partners • Sector Ministries • Civil society organizations • Private sector agencies	
f) Joint review reports	NSF mid-term and end-term	• Data on achievements against all the NSF input, output, outcome and impact indicators • Main challenges faced in achieving desired NSF results • Main recommendations to strengthen achievement of desired results • Assessment of: program management, M&E, financial management, relevance, sustainability and appropriateness of interventions	All HIV and AIDS stakeholders including: • Sector Ministries • Civil society organizations • Private sector agencies • Parliament and Cabinet • NAC Commissioners • International Development partners	Two months after the mid-term and end-term of NSF periods
g) Research, surveys and surveillance reports	After completion of research, surveys and surveillance	• As per the research, survey and surveillance protocol	• Stakeholders specified as key audience in the research, survey and surveillance protocol	Two months after completion of data collection

SECTION 4: HOW THE M&E SYSTEM FUNCTIONS

4.1 INTRODUCTION

This section explains how the M&E system functions through the twelve components of the M&E system by describing each of the components. These twelve components include the: Organizational structures for M&E; Human capacity for M&E; M&E Partnerships; M&E plan; Costed M&E work plan; M&E Advocacy, communications and culture; Routine Monitoring; Periodic Surveys and Surveillance; Databases; Supervision and data auditing; Evaluation and research and; Using information to improve results.

4.2 ORGANIZATIONAL STRUCTURES FOR M&E

4.2.1 The structure of the Liberia national HIV and AIDS response and how M&E fits into it

The national level multi-sectoral HIV and AIDS response is managed and coordinated by The Commission. The Commission M&E Unit manages the implementation of this M&E Plan in all Government sectors, civil society organizations and private businesses. At the national levels there are also several development partner organizations which provide technical, financial and material support for implementing M&E activities at national levels. The Commission and development partners have staff responsible for various M&E related functions.

Monitoring, surveys, surveillance, research and documentation related to community based non-clinical HIV and AIDS interventions is managed by LISGIS, therefore LISGIS has M&E Officers who are placed at the head office and in all counties. MOHSW mainly through the NACP, HMIS, Blood safety program and other departments undertake monitoring, surveys, surveillance and research related to clinical HIV and AIDS issues.

National umbrella organizations of civil society and private businesses also monitor and report collectively on the HIV and AIDS work being undertaken by their constituency members. Sector Ministries are responsible for coordinating the HIV and AIDS activities within their respective sectors. Within each of these sectors, an M&E focal person manages and coordinates all M&E activities including for HIV and AIDS interventions. Furthermore, some sector Ministries like MOHSW, MOF, MOL, MOE and MoGD generate information on indicators in this M&E Plan.

Within Counties, the M&E functions are undertaken by County M&E Focal persons who work closely with the LISGIS M&E Officers. Organizations implementing HIV and AIDS interventions have community outreach officers who undertake monitoring and data collection. Within health

facilities monitoring and data collection is done by staff who deliver clinical based HIV and AIDS services.

4.2.2 Detailed structure for M&E within the Liberia national HIV and AIDS response

Below is an illustration of how M&E functions are organized within the Liberia national HIV and AIDS response at national, sectoral, county, community and health facility service delivery points:

National level structure	A The Commission Management Information Systems (MIS) Manager is in place to lead management and coordination of M&E activities in all sectors	M&E Officers within development partner agencies are responsible for managing and coordinating technical and financial support to the national M&E system	Umbrella organizations of PLHIV, CSOs and private businesses have staff assigned to monitor and report collectively on the HIV and AIDS work being undertaken by their constituency members
National levels structure reporting to NAC and partners	LISGIS has staff at the central office who are responsible for cleaning, capturing, analyzing and producing data on community based as well as clinical health facility based responses through CRIS software	MOHSW HMIS unit has staff at the central office who are responsible for cleaning, capturing, analyzing and producing data on health facility based HIV and AIDS interventions	
Sector levels	Sector Ministries have M&E focal persons responsible for managing and coordinating HIV and AIDS M&E activities in the sector	MOHSW, MOF, MOL, MOE and MoGD also have staff who are responsible for generating data for selected indicators in the national M&E Plan	
County levels	Counties have M&E Officers responsible for obtaining, verifying, cleaning, consolidating and reporting data from community implementers in the Counties	LISGIS has M&E Officers in counties who work with County M&E Officers in obtaining, verifying, cleaning, consolidating and reporting data from community implementers in the Counties	MOHSW staff in counties also participate in verification, cleaning and consolidating clinical based data from health facilities
Community and health facility service delivery points	Within organizations implementing community based HIV and AIDS interventions there are community outreach officers who monitor activities, collect and document data	Within health facilities there are health workers who monitor activities, collect and document data	

4.3 HUMAN CAPACITY FOR M&E

4.3.2 Resource persons undertaking M&E functions, main responsibilities and capacity needs

Within the national HIV and AIDS response there are various resource persons who are responsible for implementing M&E related functions at all levels. Each of these resource persons is allocated

the main tasks as listed below together with the technical knowledge and practical skills they require to fulfill the assigned tasks.

M&E resource persons	Main responsibilities	Technical knowledge and practical skills required to fulfill tasks
v. Staff performing M&E related functions in NAC	▪ Lead stakeholders to design system and develop national multi-sectoral HIV and AIDS M&E Plan, policy, guidelines and tools ▪ Advocate with stakeholders to generate and utilize strategic information ▪ Oversee and coordinate stakeholders M&E related activities ▪ Build stakeholders technical knowledge and practical skills in M&E ▪ Manage institutional strengthening of key organizations with quality assurance for the M&E system processes and products ▪ Lead development and distribution of key information products ▪ Disseminate information generated from the M&E system ▪ Maintain an inventory and report on need for and coverage of HIV training and capacity building services for resource persons ▪ Lead stakeholders through the 2012 MTR and strategic re-planning of the national multi-sectoral HIV and AIDS response	Staff should have the following knowledge and skills: ▪ Basic concepts and processes in M&E ▪ National strategic planning ▪ Development of M&E Plans and guidelines ▪ Results based management ▪ Policy advocacy, review and formulation ▪ Development of nationally harmonized data collection and reporting tools ▪ Management and organizational development ▪ M&E capacity assessments ▪ Development of M&E capacity strengthening and training packages ▪ Facilitation and training in M&E ▪ Data management ▪ Planning and implementation of joint evaluations ▪ Budgeting, advocacy and resource mobilization
w. Staff performing M&E functions in International Development Partners organizations	▪ Provide technical advice to the development and implementation of the M&E plan, tools and guidelines ▪ Facilitate shared learning on effective strategies, lessons learnt and experiences on M&E systems from other countries ▪ Mobilize technical, financial, material and technological resources towards the national multi-sectoral HIV and AIDS M&E system	Staff should have the following knowledge and skills: ▪ National strategic planning ▪ Development of M&E Plans, guidelines and tools ▪ Results based management ▪ Effective strategies and lessons learnt from other countries M&E systems ▪ Budgeting, advocacy and resource mobilization
x. National TWG-MIS	▪ Make technical input on and formally approve the M&E Plan, policy, tools and guidelines ▪ Plan, oversee and evaluate the functionality of the M&E system ▪ Provide feedback and advice on strengthening	Staff should have the following knowledge and skills: ▪ National strategic planning ▪ Development of M&E Plans and guidelines

	human and institutional capacity for M&E ▪ Act as a technical think-tank for multi-sectoral HIV and AIDS M&E issues ▪ Promote monitoring, evaluation, data collection, reporting and information use among stakeholders ▪ Coordinate HIV M&E activities in their respective jurisdiction ▪ Mobilize resources for HIV M&E ▪ Review and approve research proposals	▪ Results based management ▪ Policy advocacy, review and formulation ▪ Planning and undertaking M&E capacity assessments ▪ Developing capacity strengthening and training packages ▪ Planning and implementation of joint evaluations ▪ Budgeting, advocacy and resource mobilization
y. Government Sectors Ministries	▪ Lead stakeholders in sector to design system and develop HIV and AIDS M&E section of their sector plans, policies, guidelines and tools ▪ Coordinate HIV and AIDS related M&E activities within the respective sectors including routine monitoring, research, surveys and surveillance ▪ Build technical knowledge and practical skills in M&E for sectors HIV and AIDS stakeholders ▪ Develop, distribute and disseminate HIV information products for the sector among stakeholders	Staff should have the following knowledge and skills: ▪ Development of M&E Plans, guidelines, data collection and reporting tools ▪ Management and coordination of stakeholders activities ▪ M&E concepts and processes which are relevant to the respective sectors ▪ Training and facilitation skills ▪ Documentation and report writing skills ▪ Activity planning and budgeting
z. MOHSW – NACP	▪ Lead stakeholders to design system and develop HIV and AIDS component of the health sector M&E plan, policy, guidelines and tools ▪ Coordinate HIV and AIDS related M&E activities within the health sector including routine monitoring, research, surveys and surveillance ▪ Build knowledge and practical skills in M&E for health sector stakeholders involved in HIV and AIDS interventions ▪ Develop and distribute HIV information products from the health sector ▪ Disseminate health related HIV and AIDS information among stakeholders	Staff should have the following knowledge and skills: ▪ Basic concepts and processes in M&E ▪ National strategic planning ▪ Results based management ▪ Development of M&E Plans, guidelines, data collection and reporting tools ▪ Management and coordination of stakeholders activities ▪ M&E concepts and processes which are relevant to the respective sectors ▪ Research, surveys and surveillance ▪ Planning and forecasting software models ▪ Training and facilitation skills ▪ Documentation and report writing skills

		▪ Activity budgeting
aa. MOHSW – HMIS	▪ Obtain relevant data from health facilities and health sector agencies ▪ Audit, clean and capture routine monitoring data into the HMIS ▪ Analyze and provide data from HMIS to The Commission, NACP and other stakeholders	Staff should have the following knowledge and skills: ▪ Database functions, management and maintenance ▪ Data management including capture, analysis and interpretation ▪ Documentation and report writing skills
bb. Sectors which manage data sources for indicators	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to welfare and external support needed and provided to children, PLHIV and vulnerable groups ▪ Maintain an inventory and report on need for and coverage of community based care and support services for MVC ▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to blood safety ▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to education and welfare of MVC ▪ Maintain an inventory and report on need for and coverage of MVC with education services ▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to gender equality and empowerment, gender related risk and vulnerability, SGBV, stigma and discrimination ▪ Maintain an inventory and report on need for and coverage of gender based violence survivors with basic treatment, care and support services	Staff should have the following knowledge and skills: ▪ Development of M&E Plans, guidelines, data collection and reporting tools ▪ M&E concepts and processes which are relevant to the respective sectors ▪ Research, surveys and surveillance ▪ Planning and forecasting software models ▪ Data management ▪ Documentation and report writing skills ▪ Activity budgeting
cc. MOHSW - National reference laboratory	▪ Undertake quality assurance of HIV testing and other processes related to medical routine monitoring, research, surveys and surveillance	Staff should have the following knowledge and skills: ▪ Laboratory quality assurance procedures and standards
dd. MOHSW - Liberia Institute for Biomedical Research (LIBR)	▪ Provide technical support to HIV and AIDS related research, surveys and surveillance when working closely with NACP and other stakeholders	Staff should have the following knowledge and skills: ▪ Planning , budgeting and implementation of research, surveys and surveillance ▪ Planning and forecasting software models ▪ Data management ▪ Documentation and report

		writing skills ▪ Activity budgeting
ee. MOHSW - Medical Stores Department	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to drug and commodities availability and stock outs	Staff should have the following knowledge and skills: ▪ Processes and requirements in commodities management, including procurement and supplies
ff. MOHSW – All Health Facilities	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to prevention, treatment, care, support, impact mitigation and systems strengthening issues and services provided at health facilities	Staff should have the following knowledge and skills: ▪ Monitoring ▪ Data collection ▪ Data verification ▪ Documentation and report writing skills
gg. Liberia Institute of Statistics and Geo-Information Systems (LISGIS)	▪ Obtain relevant data from stakeholders implementing HIV and AIDS activities in communities ▪ Audit, clean and capture routine monitoring data into the CRIS ▪ Provide data from CRIS to The Commission, NACP and other stakeholders	Staff should have the following knowledge and skills: ▪ Management and coordination of stakeholders ▪ Data management ▪ Data auditing, cleaning and capturing ▪ Management, operation and maintenance of CRIS ▪ Documentation and reporting
hh. Ministry of Planning and Ministry of Finance	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to poverty, employment, and MDGs through the PRS monitoring system ▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to HIV and AIDS budgets and spending	Staff should have the following knowledge and skills: ▪ Basic concepts and processes in M&E ▪ National strategic planning ▪ Development of M&E Plans and guidelines ▪ Documentation and reporting
ii. Government Counties and Districts authorities	▪ Build knowledge and practical skills of district and county stakeholders in HIV and AIDS M&E ▪ Coordinate HIV and AIDS related M&E activities among stakeholders in districts and counties including routine monitoring, research, surveys and surveillance ▪ Develop, distribute and dissemination HIV information products on behalf of their respective district or county stakeholders	Staff should have the following knowledge and skills: ▪ M&E concepts and processes ▪ Training needs and capacity assessment processes and tools ▪ Training, facilitation and communication skills ▪ Management and coordination of stakeholders activities
jj. Umbrella CSOs and private businesses	▪ Build knowledge and practical skills of member organizations to design system and develop and implement their HIV and AIDS M&E work plans ▪ Coordinate HIV and AIDS related M&E activities among the member organizations including	Staff should have the following knowledge and skills: ▪ M&E concepts and processes ▪ Training needs and capacity assessment processes and tools

	research, surveys, surveillance, monitoring and data collection ▪ Develop, distribute and dissemination HIV information products on behalf of their respective constituency group	▪ Training, facilitation and communication skills ▪ Management and coordination of stakeholders activities
kk. Civil Society Organizations implementers	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to prevention, treatment, care, support, impact mitigation and systems strengthening issues and services provided by member organizations	Staff should have the following knowledge and skills: ▪ Monitoring ▪ Data collection ▪ Data verification ▪ Documentation and report writing skills
ll. Light Association and PLHIV support organizations	▪ Monitor, collect and disseminate strategic information on HIV and AIDS which pertains to stigma and discrimination and quality of and access to HIV and AIDS services, ▪ Maintain an inventory and report on need for and coverage of services provided to PLHIV	Staff should have the following knowledge and skills: ▪ Monitoring ▪ Data collection ▪ Data verification ▪ Establishment and management of inventories, exit interviews and free telephone hotline services ▪ Advocacy and communication ▪ Documentation and report writing skills
mm. Other academic and research institutions	▪ Provide support to HIV and AIDS related research, surveys and surveillance when working closely with The Commission and NACP and other stakeholders ▪ Build technical knowledge and practical skills of stakeholders in all aspects of HIV and AIDS M&E	Staff should have the following knowledge and skills: ▪ Planning, budgeting and implementing research, surveys and surveillance ▪ Documentation and report writing skills ▪ Training needs and capacity assessment processes and tools ▪ Training, facilitation and communication skills ▪ Management and coordination of stakeholders activities

4.3.3 Process through which the technical knowledge and practical skills are developed

During the beginning and at the mid-term of NSF implementation period, a national assessment of institutional and human capacity for HIV and AIDS M&E within Liberia is undertaken. This assessment looks at technical knowledge, practical skills, available resources, and resource gaps for undertaking M&E related functions at all levels of the national HIV and AIDS response. This national assessment of M&E capacity forms the basis for development of an M&E capacity

strengthening plan. The M&E capacity strengthening plan addresses how to maintain the existing capacity strengths and how to address the capacity gaps. This capacity strengthening plan contains activities, strategies, dates, persons responsible and resources required for strengthening knowledge and skills of individual resource persons. It also contains institutions which are responsible for M&E functions at all levels of the national HIV and AIDS response.

4.3.4 Strategies and mechanisms for strengthening knowledge and skills in M&E

The Commission and stakeholders mobilize adequate resources for implementation, monitoring and reporting on the M&E capacity strengthening plan. Various strategies are employed in strengthening stakeholders knowledge and skills in M&E including but not limited to: On the job technical assistance; Long distance training courses; Internet e-learning; Twinning with academic and research institutions; Inter-country learning visits, and; Training workshops and courses.

Various mechanisms are in place for strengthening capacity in M&E. Government institutions mainstream technical knowledge and practical skills in M&E within the pre-service and in-service training packages for various professionals in all sectors. M&E modules are also included in refresher training packages offered by Government institutions in various sectors. Degrees, diplomas and short courses and workshops are organized at local, national and international levels as a mechanism for strengthening capacity in M&E. On an annual basis The Commission and stakeholders assess implementation of the capacity strengthening plan and updates activities as well as budgets contained therein.

4.4 M&E PARTNERSHIPS

NASCOP maintains an updated list of health facilities together with the HIV and AIDS interventions which they undertake. The inventory also specifies contacts, location as well as capacity of the health facilities. The Commission also undertakes a mapping of stakeholders who implement or support non-clinical HIV and AIDS activities within communities. This inventory specifies the stakeholders, services they provide, where they are located, their contacts as well as their capacities. These inventories are constantly updated and used for planning and also selecting the organizations who should be members of the national TWG-MIS.

4.4.1 Mandate and purpose of TWG-MIS

The TWG-MIS is a multi sectoral team of stakeholders who are involved in HIV and AIDS M&E activities while representing various sectors and technical disciplines. This TWG has been established with a purpose to advise and oversee the process of developing, functionality and

management of the national multi-sectoral HIV M&E system for Liberia. The TWG is in place for the lifetime of the national HIV and AIDS M&E Plan 2010-2014.

The overall goal of the TWG is to make the national HIV M&E system work by providing technical oversight over multi-sectoral HIV and AIDS M&E system. Activities in this system are aimed at generating and disseminating high quality, relevant, timely, and strategic information that guides stakeholders to improve quality, access and utilization of HIV and AIDS services. The TWG also provides technical advice all other information systems which contain strategic information and HIV and AIDS including HMIS, CRIS, gender information system and others.

The TWG has the following objectives: To make technical input on and formally approve the M&E Plan; To plan, oversee and evaluate the functionality of the M&E system; To provide feedback and advice on strengthening human and institutional capacity for M&E; To act as a technical think-tank for multi-sectoral HIV and AIDS M&E issues; To promote monitoring, evaluation, data collection, reporting and information use among stakeholders; To coordinate HIV M&E activities in the country, and; To mobilize human, financial, technological and material resources for undertaking HIV M&E.

4.4.2 Process and criteria for selection of TWG-MIS members

The TWG is convened by The Commission. The TWG Secretary is the M&E Coordinator at The Commission. The Leadership of the TWG is nominated annually by the members through a consensus building session which ensures that more than 50% of the TWG members are agreeable to the selected choice. The TWG is composed of M&E staff from stakeholder organizations in different sectoral disciplines and from various sectors including Government Sector Ministries, Civil Society, Private sector and International Development Partners. The TWG members are selected based on if their interest, goals and objectives being in sync with those of the TWG.

4.4.3 Other partnership mechanisms and routine communication channels

At the international level Liberia participates in M&E TWG within the Economic Community of Western African States (ECOWAS). Liberia also undertakes joint M&E initiatives with other countries. Communication for the multi-country M&E initiatives is done through email, internet, workshops and joint reporting activities. Liberia also participates in regional and global M&E and reporting forums like UNGASS, MDGs, UN-CRC and others.

4.5 M&E PLAN

4.5.1 How the M&E plan is reviewed

This M&E plan has been developed in 2010 to cover 5 years period in line with the NSF period of 2010-2014. The M&E Plan will be reviewed and updated during the MTR in 2012. During the MTR most of the data sources in the M&E Plan will have generated critical information for re-planning the NSF for the remaining period up to 2014. Therefore this M&E Plan will be realigned to the updated NSF for the second phase of the NSF implementation period from 2012 up to 2014. Furthermore during the MTR the status of implementation of the M&E system will be assessed using the 12 components organizing framework, M&E Systems Strengthening (MESS) tool and other frameworks that may be in place. The assessment will focus on the M&E system at national, counties, community service delivery point, health facilities service delivery point as well as various sectors. The assessment findings will be used to update various components of the M&E system. The assessment will be participatory and involve all critical stakeholders in providing opinions and recommendations to strengthen the HIV and AIDS M&E activities.

4.6 COSTED M&E WORK PLAN

On an annual basis The Commission and the TWG-MIS members lead stakeholders in developing the costed national M&E work plan. This work plan contains all the M&E activities that are to be undertaken by all stakeholders, in all sectors. The costed M&E work plan outlines the specific M&E activities to be undertaken, implementation dates, those responsible for implementation, resources and budgets required for implementation of activities.

The costed M&E work plan is critically reviewed and updated through widespread stakeholder consultation. When the M&E work plan is finalized, The Commission defines the available resources and potential resource gaps. After that The Commission negotiates with possible financing sources to support the identified resource gap. The Commission mobilizes technical, financial and material resources for implementation of work plan activities from various international partners, Government budgets as well as local HIV and AIDS stakeholders.

In order to facilitate mobilization of budgets from Government sources, the M&E work plan activities are included in the overall The Commission annual plan and budget which is integrated into the Ministerial annual budget that is in turn presented to MOF for financing. At the County levels as well, HIV and AIDS M&E activities are included in the annual County plans and budgets which are presented for Government financing.

4.7 M&E ADVOCACY, COMMUNICATIONS & CULTURE

In order to make sure that adequate resources are mobilized, thereby strategic information is generated, disseminated and properly utilized, M&E advocacy and communication efforts are undertaken targeting key stakeholders with specific messages as shown in the table below:

Key target audiences with whom to communicate	Key messages to be conveyed to these target audiences	Typical communications and advocacy strategies
Key Government Officials	• Importance of adopting favorable laws, policies, guidelines and strategies which support M&E • Need to allocate technical, material and financial resources for M&E	Lobbying meetings with Government officials
International development partners who support HIV and AIDS interventions	• Need to allocate technical, material and financial resources for M&E	Lobbying meetings with development partners representatives
Civil society organizations, Health facilities and Private businesses who implement HIV and AIDS activities	• Importance of monitoring, data collection, data analysis and report writing • The need to interpret and utilize strategic information for making decisions which improve program interventions and quality of services	Stakeholders dialogue meetings Printed Information Education and Communication (IEC) materials
Chief Executives and Heads of Government, Civil society and private business	• Importance of adopting favorable laws, policies, guidelines and strategies which support M&E resource mobilization • Need to allocate human, material and financial resources for organizations M&E activities	Stakeholders dialogue meetings

4.8 ROUTINE MONITORING

Community outreach staff and health workers monitor and report HIV and AIDS related data on a routine basis. In the community outreach programs data sources which generate data for the indicators in the M&E system on a routine basis include: CRIS; HMIS; The Commission MIS; MOE MIS; NACP MIS; Blood Safety MIS; Light Association telephone hotline; Light Association exit interviews, and; Light Association PLHIV database. Several data collection tools are used for generating data for these sources including: Training registers; IEC and condom distribution log sheets; telephone hotline forms; Exit interview questionnaires; PLHIV inventory and questionnaires, and; Routine monitoring reports of MOL, MOE, The Commission, counties, Sectors and all stakeholders routine monitoring reports.

Within the health sector the routine data sources include HMIS, NACP MIS as well as the blood safety MIS. Several data collection tools are used for generating routine data in clinical settings including: ART survival rate forms; PMTCT registers; Spectrum estimation software; HIV counseling and testing registers; Outpatient department (OPD) register for condoms for prevention; FP register for condoms for contraceptive use; ANC registers; Training registers; Frame tool for blood safety; ART registers and reports; stock cards and drug consumption books; Monitoring reports of NACP and the National Blood Safety Program.

Routine monitoring data for non-clinical community based HIV and AIDS interventions are captured on forms which are submitted by implementers to the LISGIS County level offices. The LISGIS County office verifies and cleans then consolidates county data and submits it to LISGIS Central office through the CRIS software. On the other hand, routine monitoring data for clinical health facility based responses are submitted on a monthly basis by health facilities to the HMIS while also copying district authorities. HMIS unit reviews, cleans and the captures the data into the HMIS.

HIV and AIDS data contained in the HMIS data is in turn exported to the CRIS software which is hosted by LISGIS. The LISGIS central office works with the Commission, NACP and HMIS to consolidate, analyze, interpret all the national community and clinical based HIV and AIDS data into a report which is then disseminated to stakeholders.

4.9 SURVEYS AND SURVEILLANCE

The main surveys and surveillance which are undertaken to generate data for the M&E system include the LDHS, MARPs Bio-BSS, NCPI and NASA. The spectrum estimation model is also used for projections of selected indicator values.

a. LISGIS commissions the LDHS which is a population based survey taking place every 4 to 5 years. The LDHS applies a survey protocol based on international standards for DHS. Data is captured in communities by the survey team. This data is then cleaned, analyzed and used to produce the LDHS report at the LISGIS central office. The LDHS report is disseminated among all interested stakeholders nationally and internationally.

b. LISGIS also undertakes MARPs Bio-BSS every 2 years using a survey protocol developed in line with the UNAIDS/WHO or FHI guidelines for surveys among MARPs. Data is captured in communities by the survey team. This data is then cleaned, analyzed and used to produce the MARPS Bio-BSS report at the LISGIS central office. The LDHS report is disseminated among all interested stakeholders nationally and internationally.

c. The Commission NCPI survey every 2 years using NCPI questionnaire applied for UNGASS reporting. NCPI data is collected from HIV and AIDS stakeholders in Government, civil society and private sectors. This data is then cleaned, analyzed and used to produce the NCPI. The NCPI index is reported through the UNGASS report. The UNGASS report is disseminated to interested stakeholders in-country as well as at the UNGASS meeting.

d. MOF undertakes the NASA annually using the NASA questionnaire. Data for the NASA is collected from HIV and AIDS stakeholders in Government, civil society and private sectors. This data is then cleaned, analyzed and used to produce the NASA report. The NASA report is disseminated to interested stakeholders in-country.

e. NACP uses the spectrum estimation model to generate indicator data annually through the spectrum software. Data is originated from health facilities which capture it into spectrum. NACP analyses and captures the data into the HMIS while providing feedback to health facilities. HMIS in turn exports the data to CRIS.

4.10 DATABASES

Values of indicators contained in this M&E Plan are obtained from already existing information systems. The CRIS software which is hosted at LISGIS acts as a repository containing all clinical and non-clinical community based strategic information on HIV and AIDS within the country. On the other hand, the HMIS database which is hosted by the HMIS unit of MOHSW contains strategic information on clinical HIV and AIDS issues in the country.

Other information systems which generate and provide data for the CRIS and HMIS include but are not limited to: Spectrum estimation software hosted by the NACP; PRS monitoring system hosted by Ministry of Planning; Financial monitoring system of the MOF; The SGBV database hosted by MoGD; MOE monitoring system; Blood safety monitoring system; LMIS monitoring system; MOL monitoring system, and; PLHIV monitoring system at Light Association. All these information systems should be linked by 2014 so as to be able to directly import and export HIV and AIDS data in an electronic manner.

4.10 SUPERVISION AND DATA AUDITING

On a quarterly basis, data auditing and supportive supervision is undertaken to assure quality of data generated in the national M&E system. Data generated by implementers within counties is audited by the Counties M&E officers. Data submitted by Counties is audited by LISGIS and The Commission. On the other hand data on clinical services submitted by health facilities is audited by NACP and HMIS officials every quarter. Data auditing is planned, undertaken and reported on based on national guidelines for data auditing and supportive supervision. The data auditing and supportive supervision guidelines are developed and updated by the TWG-MIS under leadership of the Commission. The guidelines stipulate how stakeholders are selected for data auditing, how the data auditors make preparations to undertake data auditing, how actual data auditing is undertaken, how data auditing findings and recommendations are documented and steps for follow up made on recommendations.

4.11 EVALUATION AND RESEARCH

4.12.1 National evaluation and research

At commencement and mid-term periods of the NSF implementation, The Commission undertakes an assessment of stakeholders HIV and AIDS information needs. Following the Commission leads the TWG-MIS to develop a national inventory of completed and ongoing country specific evaluation and research studies. This inventory highlights what information needs have been fulfilled through research and evaluation, as well as gaps in information which need to be met through research and studies.

Based on the analysis of information gaps, The Commission leads the TWG-MIS to develop a national HIV and AIDS research strategy. This HIV and AIDS research strategy is implemented by The Commission while working closely with national and international research institutions

through an annual research agenda which is developed by the TWG-MIS. In order to meet the HIV and AIDS information needs of stakeholders, the main research studies which will be undertaken to generate strategic information within the NSF during 2010 to 2014 period are as follows:

Focus of research	Organization commissioning research	Year of implementation				
		Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Drivers of the epidemic	National AIDS Commission		✓	✓		
Modes of HIV transmission	NAC/NACP		✓	✓		
Identification of MARPS and vulnerable groups	NAC		✓	✓		
Universal access to HIV services	NAC/NACP					
Gender and HIV and AIDS	NAC		✓	✓		
Men's involvement in HIV and AIDS interventions	NAC			✓		
Service availability mapping	NAC/NACP		✓	✓		
Impact of Behavior change communication	NAC/NACP			✓		
Extent of and factors influencing use of male and female condoms	NAC			✓		
Traditional practices which facilitate spread and impact of HIV	NAC			✓		
Adolescents' risk and vulnerability to HIV and AIDS	NAC			✓		
Effectiveness of VCT and PITC	NAC			✓		
Male circumcision and HIV and AIDS	NAC			✓		
Impact of HIV and AIDS	NAC				✓	
Nutrition and HIV and AIDS	NAC					
Adherence to treatment	NAC/NACP			✓		
Burden of HIV and AIDS care	NAC/NACP			✓		
OVC situation analysis	NAC/NACP		✓			
PLHIV situation analysis	NAC		✓			
Experiences and lessons learnt in implementing HIV and AIDS activities	NAC/NACP					✓
Stigma and discrimination	NAC		✓			
Joint mid-term review of the NSF	NAC, TWG MIS and all stakeholder			✓		
Joint end-term review of the NSF	NAC, TWG MIS and all stakeholder					✓

4.12.2 Procedures and guidelines for ethical review and approval of research

Procedures for ethical review as well as guidelines on evaluation and research standards are developed and updated by the TWG-MIS. In addition to research, a stakeholders' joint national review of the implementation of the NSF will take place at the mid-term and end-term of NSF implementation period. Research and evaluation findings are disseminated through various channels including: stakeholder meetings, internet, websites, physical delivery of reports and associated IEC materials.

4.12.3 The joint MTR and end-term reviews of the NSF implementation

The Commission will lead stakeholders in the joint MTR and end-term reviews of NSF implementation will be undertaken to evaluate the overall efficiency and effectiveness of the HIV and AIDS response in Liberia. The MTR will focus on processes, outputs and outcomes of the NSF implementation. The end-term review will focus on outcomes and impacts of the NSF implementation. Among other issues, the MTR will determine: Whether services have reached all the beneficiaries targeted by NSF; Challenges and constraints which hamper service delivery; Recommendations to address bottlenecks to service delivery, and; If the national AIDS response is well managed and achieving the targets set in the NSF.

Among other issues, the end-term review will determine: If HIV services which were provided for the beneficiaries fulfilled the indicator targets as set in the NSF; How implementing the NSF has caused changes in knowledge, attitudes, practices, behavior and general wellbeing of those targeted with services; Whether there has been a reduction in HIV prevalence or incidence; If the quality of life of PLHIV and other affected populations has improved; Whether the national AIDS response has achieved its desired results, and; Recommended actions to optimize achievement of desired results of the NSF implementation.

4.13 USING INFORMATION TO IMPROVE RESULTS

4.13.3 Information products produced from the HIV and AIDS M&E system

The main information products which are developed under The Commission leadership using data in the national M&E system include: quarter brochure; six months coverage reports; annual newsletter; annual HIV and AIDS reports; two year UNGASS report; joint review reports, and; research, surveys and surveillance reports.

a) The quarter brochure contains key highlights of achievements of national response as well as main recommended actions to strengthen national response. This brochure is disseminated to all HIV and AIDS stakeholders including: Sector Ministries; Civil society organizations; private sector agencies; national legislature and cabinet; The Commission commissioners, and; international development partners.
b) The six months coverage reports focus on: Main activities that transpired in the AIDS response; data on achievements against all input and output indicators; main challenges faced in achieving desired output and input results, and; main recommendations to strengthen achievement of output and input results. These reports are also disseminated to all HIV and AIDS stakeholders.
c) The annual newsletter highlights: Local and international news updates relating to HIV and AIDS; calendar of HIV and AIDS events at local and international levels; Main activities that

transpired in the HIV and AIDS response, and; Achievements, lessons learnt, best practices and challenges in the national HIV and AIDS response. This newsletter is also disseminated to all HIV and AIDS stakeholders including national legislature and cabinet.

d) The annual HIV and AIDS report contains the: Main activities that carried out in the HIV and AIDS response; data on achievements against all the NSF input, output, outcome and impact indicators; main challenges faced in achieving desired NSF results; main recommendations to strengthen achievement of desired results; report on the status of the M&E system, and financial report. This report too is disseminated to all HIV and AIDS stakeholders including national legislature and cabinet.
e) The two year UNGASS report covers: Data on achievements against all UNGASS indicators; main challenges faced in achieving results measured through UNGASS indicators, and; main recommendations to strengthen the national HIV and AIDS response. This report is disseminated to all HIV and AIDS stakeholder as well as the United Nations General Assembly Special Session on HIV and AIDS.
f) The mid-term and end-term joint review reports provide feedback on: Data on achievements against all the NSF input, output, outcome and impact indicators; Main challenges faced in achieving desired NSF results; Main recommendations to strengthen achievement of desired results, and; Assessment of program management, M&E, financial management, relevance, sustainability and appropriateness of interventions. This report is disseminated to all HIV and AIDS stakeholders including national legislature and cabinet.
g) Research, surveys and surveillance reports are developed based on the study tools and protocols. These reports are disseminated selected stakeholders who are in a position to interpret, and utilize the study findings in their respective HIV and AIDS interventions.

4.13.4 How the information products are disseminated

The information products disseminated from the HIV and AIDS M&E system are disseminated to stakeholders through several mechanisms. These mechanisms include but are not limited to the following: hard copies and electronic information products being available at the Commission resource centre; electronic information products being availed The Commission website; hard copies of information products being distributed and discussed at stakeholder meetings; electronic information products being distributed and disseminated to stakeholders through email communication; hard copy information products being distributed and disseminated to stakeholders through physical delivery by post or courier and; discussion of the key findings of the information products through mass media mainly radio, television and newspaper. during the MTR and end-term review of the NSF implementation, the extent to which information shared has been applied by stakeholders in improving their program design and quality of services will be assessed.

SECTION 5: CONCLUSION AND WAY FORWARD

This Liberia National Multisectoral HIV and AIDS M&E Plan will be implemented from the year 2010 to 2012 as aligned to the National HIV Strategic Framework II 2010-2014. This plan is implemented to generate and disseminate high quality, relevant, timely and strategic information that guides stakeholders to improve quality, access and utilization of HIV and AIDS services.

As an immediate step to operationalize this plan, the Commission will convene and lead stakeholders to develop a costed work plan of M&E activities. The work plan identifies specific M&E related activities which should be implemented in line with this Plan, prioritizes what actions should be done first, defines dates for implementation of each action together with organizations primarily responsible, and establishes resources which are required for implementing each activity. The work plan is organized in order of the 12 components of the national M&E system.

On an annual basis the Commission works with stakeholders to identify the M&E activities to be implemented in the current year. The Commission and stakeholders estimate the annual M&E activities and budgets. The Commission then leads stakeholders to identify sources of support and mobilize resources for implementing each of the activities.

Among the activities which the Commission places priority on planning, mobilizing resources for and implementing include:

1) Printing, launch and dissemination of the National Multisectoral HIV and AIDS M&E Plan
2) Development of simplified, easy to read and interesting booklets, posters and brochures explaining the M&E system
3) Creating awareness to enhance understanding of all key stakeholders of the National Multisectoral HIV and AIDS M&E system and their expected roles
4) Advocacy with all stakeholders to mobilize resources and undertake their M&E roles which include generation and usage of strategic information
5) M&E capacity assessment followed by on-going building of skills and knowledge to enable all stakeholders to implement their roles
6) Development and implementation nationally harmonized training packages as well as data auditing and supportive supervision guidelines
7) The baseline survey to determine values of all indicators in the M&E system
8) Planning session to set nationally agreed upon targets for each of the indicators
9) Development and implementation of a national prioritized agenda for research, surveys and surveillance

10) Harmonization or development of nationally agreed upon data collection plans, protocols and tools which are pretested and finalized

11) Collecting data through routine monitoring, surveys and surveillance which are prioritized

12) Development and dissemination of information products

This M&E Plan is a tool which will enhance not only understanding but also planning and coordination of activities within the national HIV and AIDS response in Liberia. The Commission and stakeholders will ensure that adequate resources are mobilized and the organizations responsible for implementing activities contained in this Plan undertake activities to an optimum level.

The Commission will supervise and oversee implementation of activities contained in this Plan on a routine basis. On an annual basis the Commission, TWG-MIS and other stakeholders will review implementation of activities in this Plan and propose activities and budgets for the upcoming year. This annual meeting will provide solutions to challenges and propose activities to enhance collection and usage of strategic information so as to improve planning, implementation and policies in the national HIV and AIDS response.